CLEARINGHOUSE

MEDICAID QUALITY CONTROL

THE REVIEW PROCESS Section 3000

DEPARTMENT OF HEALTH, EDUCATION & WELFARE
HEALTH CARE FINANCING ADMINISTRATION
MEDICAID BUREAU
Division of Quality Control

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TABLE OF CONTENTS

Chapter			Page
3100	INTRODUCTION		1
	3110	Background	1
	3120	Expanded Medicaid Quality Control System	1
	3130	MQC Review Cycle	6
	3140	Federal Monitoring	10
	3150	Reference Documents	10
3200	QC REVIEW REQUIREMENTS		1
	3210	Definitions of Key Terms	1
	3220	Role of the Reviewer	1
	3230	Independence of the MQC Review	3
	3240	Documentation of Reviews	3
	3250	Record Maintenance	3
3300	ELIGIBILITY QC REVIEW POLICY		1
	3310	Eligibility Overview	1
	3320	Definition of an Eligibility Error	2
	3330	QC Findings Which are not Eligibility Errors	4
	3340	Dollar Amount of an Eligibility Error.	4
	3350	Changes in Status Which do not Result in an Eligibility Error.	5

TABLE OF CONTENTS (Continued)

apter			Page
	3360	Changes in Coverage Requirement Which do not Result in an Eligibility Error	5
	3370	Reporting of Eligibility Errors	6
	3380	Acceptable Reasons for Dropped Reviews	6
	3390	Unacceptable Reasons for Dropped Reviews	7
00		ELIGIBILITY QC REVIEW PROCESS	1
	3410	Purpose of the Eligibility QC Review Process	1
	3420	Approach to MQC Eligibility Determination and Identification of Third Party Resources	1
	3430	Cases to be Reviewed	4
	3440	Case Record Review	5
	3450	Field Investigation	15
	3460	Information and Verification Requirements by Element	19
	3470	Verification Guide	58
	3480	Worksheets: Eligibility and Identification of Potential Third Party Liability	80
	3490	Completion of the Eligibility QC Review	101
00		THIRD PARTY LIABILITY REVIEW	1
	3510	Introduction and Purpose	1
	3520	Third Party Resources	2

TABLE OF CONTENTS (Continued)

Chapter			Page
	3530	Third Party Liability QC Policy	20
	3540	Preparation for TPL Review	29
	3550	Verification of a Third Party Resource	30 30
	3560	Verification of State Actions to Recover Third Party Funds	42
	3570	TPL Worksheets and Error Calculation.	44
	3580	Completion of the Review Schedule for Third Party Liability	49
3600		CLAIMS PROCESSING REVIEW	1
	3610	Purpose and Scope of the Review Process	1
	3620	Description of Error Classification Scheme	6
	3630	Review Process Documentation and Procedures	13
	3640	Completion of Review Schedule	20
3700		MQC REVIEW COMPLETION	
	3710	Purpose	1
	3720	Determining Gross Dollar Amounts of Eligibility And Liability Errors	1
	3730	Computing Unduplicated Totals of Medicaid Dollars Paid in Error	6
	3740	Completion of the Review Schedule	19

INDEX OF EXHIBITS

EXHIBIT NO.		PAGE
3100-1	Medicaid Quality Control Process	3
3100-2	MQC Cycle	9
3400-1	Medicaid Quality Control Facesheet	8
3400-2	Medicaid Quality Control Worksheet	12
3500-1	TPL Dollar Measurement Guide	25
3500-2	TPL Review Worksheet	45
3500-3	Summary of Third Party Liability Errors. . . .	49a
3500-4	Service Type Codes	53
3500-5	Codes for Third Party Resources	54
3600-1	Flow Diagram of Claims Processing QC Review .	5
3600-2	Error Situation Profile.	7
3600-3a	Claims Processing QC Summary Sheet	17
3600-3b	Claims Processing QC Worksheet	18
3700-1	Three Level Error Hierarchy.	7a
3700-2	Unduplicated Dollar Error Amount Worksheet . .	9
3700-3	Unduplicated Dollar Error Amount Worksheet . .	11
3700-4	Unduplicated Dollar Error Amount Worksheet . .	12
3700-5	Unduplicated Dollar Error Amount Worksheet . .	14
3700-6	Unduplicated Dollar Error Amount Worksheet . .	16
3700-7	Unduplicated Dollar Error Amount Worksheet . .	20
3700-8	Summary of Payment Errors - Review Schedule .	23

3100 INTRODUCTION

The purpose of this Chapter is to provide the QC reviewer with a general overview of the background, purpose, and scope of the Medicaid Quality Control (MQC) process. Subsequent sections of this Manual provide specific procedures for each phase of the process.

3110 BACKGROUND

The Medicaid Quality Control System is operated by the State Title XIX agency to monitor and improve the administration of its Medicaid program. The system is based on a monthly review of Medicaid beneficiaries identified through statistically reliable Statewide samples of cases selected from the eligibility files. These reviews are conducted to determine whether or not the sampled cases meet applicable State Title XIX eligibility requirements and that the amounts paid to provide Medicaid services for these cases were correct.

The MQC review is conducted in accordance with Medicaid eligibility and claims payment policy of each State in effect as of the review month and the procedures incorporated in this section of the QC manual.

For the purposes of MQC, State Medicaid eligibility and claims payment policy is defined as all written policy instructions issued by the State for administering the Medicaid program so long as those instructions are clearly consistent with either the State plan or proposed amendments thereto which have been submitted to, but have not been acted upon by the Health Care Financing Administration. Should inconsistencies exist the provisions of the State plan shall prevail.

The information gathered from these reviews provides the basis for planning corrective action to reduce erroneous Medicaid payments.

3120 SCOPE OF MQC SYSTEM

The Medicaid sample population includes the AFDC and SSI recipients of cash assistance and those who are eligible for medical assistance only (MAO), i.e., not eligible for cash assistance. The State MQC system will combine the samples drawn in the AFDC-QC and SSI-QA systems with an independent sample of the MAO population, and in some States where the SSI-QA sample is too small, a supplemental sample of the SSI population to obtain a representative sample of its entire Medicaid population.

This population is subject to the MQC review process which encompasses verification of eligibility, utilization of third party resources (e.g., insurance coverage) that may be available to pay for a beneficiary's medical expenses and correctness of the claims payment process.

3121 MQC Operation

The essential steps in the MQC operation are as follows:

1. Each month, draw a representative sample of cases from the eligibility file;

2. Review the eligibility status of sampled cases for the review month and identify potential third party liability;

3. Subsequently, assemble the paid claims of the sampled cases for services received during the designated review month;

4. Conduct the review of paid claims for claims processing and third party liability errors;

5. Compute payment error rates on the basis of total dollars paid in error to total dollars paid by Medicaid, for the given review month.

An overview of the Medicaid Quality Control System (MQCS) is provided in Exhibit 3100-1.

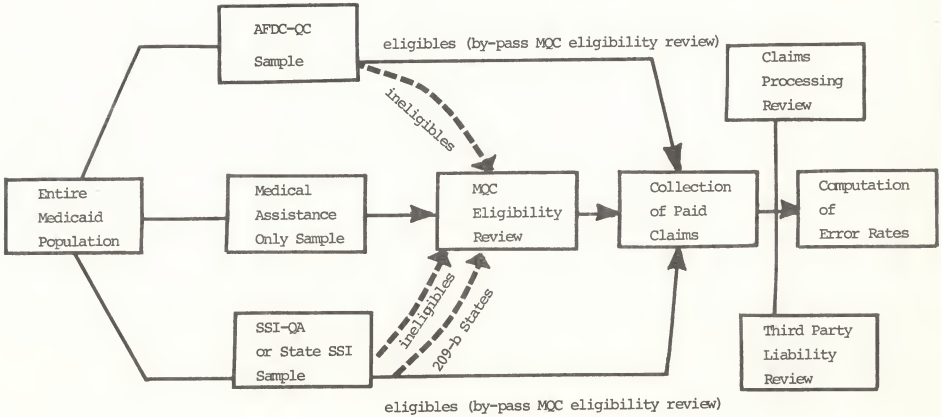
The sample will be selected as shown in Exhibit 3100-1. The sample includes: cases covered by AFDC-QC, cases covered by SSI-QA, and Medicaid cases not covered in the AFDC/SSI samples; i.e., MAO and other SSI cases when required. The QC system will operate in the following manner for the AFDC and SSI populations:

1. For AFDC, the State MQC staff will collect claims for all State selected AFDC-QC sample cases. Those cases found to be ineligible by AFDC-QC review will be reviewed by the State MQC staff to determine Medicaid eligibility for reasons other than receipt of AFDC cash payments. For cases found eligible by AFDC-QC, no further eligibility review will be conducted by State MQC staff.

2. For SSI, the State MQC staff will collect claims for all cases sampled for which a Medicaid card has been issued. SSI-QA cases which do not appear on Medicaid eligibility

EXHIBIT 3100-1

MEDICAID QUALITY CONTROL PROCESS



files will be dropped. Ineligible cases will be reviewed to determine if they were eligible for Medicaid under a coverage code other than as an SSI recipient. For States with more stringent Medicaid eligibility requirements for SSI recipients (209-b States), the MQC reviewers will conduct a review to determine if these cases meet the State's more restrictive eligibility criteria or were eligible for Medicaid under a coverage code other than as an SSI recipient.

3. States which independently determine Medicaid eligibility of SSI recipients, may independently sample their SSI population. If this option is selected, States must conduct a complete field review for each case sampled.

As illustrated in Exhibit 3100-1, MQC eligibility review will be carried out in the following types of Medicaid sample cases:

1. AFDC-QC cases that were found ineligible for AFDC payments;

2. Medical assistance cases not included in AFDC-QC and SSI-QA sample;

3. SSI-QA cases that were found ineligible for SSI payments;

4. SSI-QA cases in 209-b States having eligibility criteria for Medicaid that are more stringent than Federal requirements;

5. SSI cases not included in SSI-QA sample.

3122 MQC Eligibility Review

The MQC eligibility review process will include:

1. Eligibility review of a probability sample of cases drawn from the Medicaid eligibility file for a specified review month.

2. All members for the case are reviewed for eligibility for the specified review month.

3. Review procedures include an identification of other health insurance or third party liability coverage for each member in the case.

4. The scope of the eligibility review is extended to SSI-QA and AFDC-QC sample cases, where appropriate.

3123 Collection Of Paid Claims

For all members of all sampled cases, all paid claims for each member receiving services during the review month will be assembled from the State's paid claims files. A claim is defined as a specific line item on a provider voucher that represents dollars charged for a specific service. There may be one or more claims listed on any given provider voucher or invoice.

3124 Third Party Liability Review

Third party liability (TPL) for MQC is defined as those payment resources available from both private and public health insurance, and from other liable third parties, that can be applied toward Medicaid beneficiaries' medical expenses. The purpose of the TPL review is to verify that the State took appropriate measures to identify and collect third party payment for any claim for which the QC reviewer can determine that third party liability resources were available. Since by law, Medicaid is the last payor, failure of a State to take action to recover such funds from a third party, for which liability can be established, represents a third party liability error on the part of the State. Instructions for identifying and placing dollar values on TPL errors are provided in Chapter 3500 of this Manual. The scope of the TPL review focuses on:

1. Did the beneficiary have health insurance during the review month?

2. Was there some other third party source, such as liability insurance, available to pay for services during the review month?

3. Was third party coverage known to the State?

4. Did the State take action to recover third party funds prior to paying the Medicaid claim or before the end of the month following the month in which the payment was made?

5. If third party payments were available and not properly utilized, how much was inappropriately paid by Medicaid?

The third party liability portion of the MQC review process cannot begin until claims for services received by the case members during the review month have been received and paid by the State.

3125 Claims Processing Review

The claims processing review entails an examination of each line item (claim) on a provider invoice or voucher that has been paid in order to determine that service provided and the amount of payment was appropriate, accurate, and done in accordance with Medicaid policy. Instructions for identification of CP errors are provided in Chapter 3600 of this Manual.

3126 Classification Of Errors

The QC process results in the following types of errors:

1. Eligibility and liability errors - An eligibility or liability error exists when a beneficiary and/or case does not meet all elements of eligibility or when the liability is incorrectly determined.

2. Third party liability errors - Third party liability errors exist when there is a third party(ies) which is available to pay for medical services for the beneficiary(ies) but the party(ies) were not known to the State agency or were not fully utilized by the State agency.

3. Claims processing errors - A claims processing error exists when claims were paid which did not contain all necessary information, which did not meet service or payment restrictions, or which did not reflect liability accurately.

This Manual contains instructions for identifying these errors.

3127 Computation of Dollar Errors

Chapter 3700 contains instructions for calculating the gross dollar amounts for each type of error and the unduplicated amount (net effect) of multiple types of error.

3130 MQC CYCLE

The MQC cycle is described in Exhibit 3100-2.

The sampling period for MQC reviews is six months, October through March and April through September. Samples are drawn monthly, case reviews completed, and findings reported within the following time frame:

3131 Eligibility Reviews

1. MAO Cases. Eligibility reviews are to be completed by State MQC reviewers within 3 months after the review month. State monthly reports of completions will permit Federal MQC reviewers to select their sub-sample. These Federal reviews are to be completed within 4 months after each review month.

2. AFDC-QC Cases. State AFDC-QC eligibility reviews are expected to be completed within 2 months after the review month, Federal AFDC-QC reviews within 3 months after each review month. State MQC review of ineligibles which commences with the completion of State AFDC-QC reviews is expected to be completed within 4 months after each review month. Federal MQC reviews which follow the Federal AFDC-QC reviews are expected to be completed within 5 months after each review month.

3. SSI-QA Cases. SSI-QA sample is drawn by the 20th of the month following the review month and is expected to be 80-85% completed two months later and 100% complete 4 months later. State MQC review of the ineligible cases will commence two months after the SSI-QA sample is drawn and is expected to be completed within 6 months after the review month. Federal reviews are to be completed within 7 months of the review month.

4. Independent State Sample of SSI Population. These cases are expected to be completed in the same time frame as the MAO cases.

3132 Claims Reviews

At the start of the 6th month following a review month, States will commence their MQC claims reviews. These reviews will be limited to those claims paid on behalf of the cases sampled in a review month which were paid during the review month and the 4 months following the review month. Note that 1 month has been allowed after payments in the fourth month to permit initiation of corrective action required to adjust incorrect payments and identify TPL prior to commencing TPL and claims processing error reviews.

3133 Reports

1. States are required to report progress in completing their reviews by telephone on a bi-weekly basis.

2. On a monthly basis, States will identify the reviews they have completed.

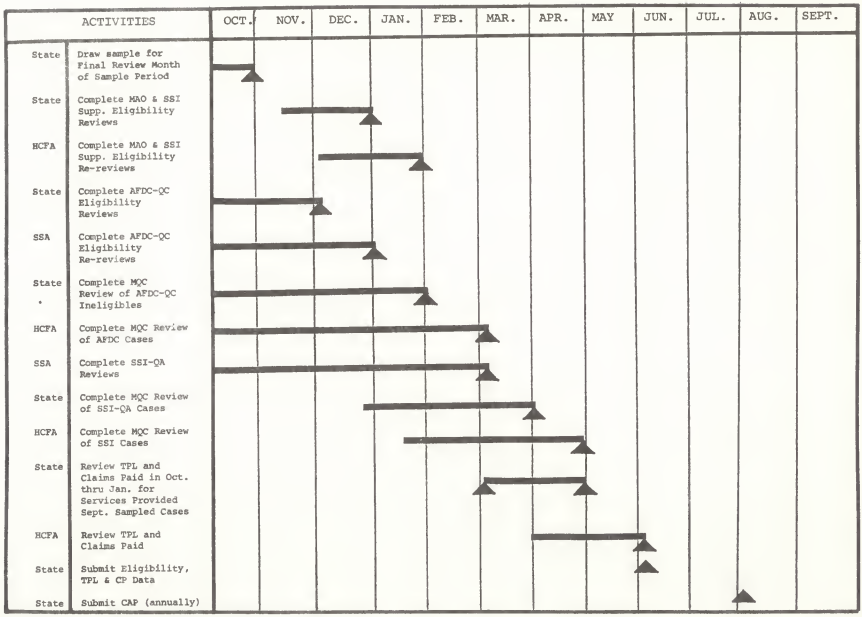
3. Within 8 months of the close of a sample period, States will submit eligibility, TPL and claims processing data.

4. Within 10 months of the completion of the April through September sample period, States will submit annual corrective action plans for reducing their error rates.

EXHIBIT 3100-2

MQC CYCLE

FOR THE CLOSEOUT OF AN APRIL THROUGH SEPTEMBER SAMPLE PERIOD



3140 FEDERAL MONITORING

To ensure that State QC systems are operating in accordance with Federally established requirements and to assist each State agency in fully utilizing its QC system, Federal staff will conduct ongoing appraisals of State operations. The Federal appraisal consists of:

1. Annual management reviews of the administrative and operational aspects of the system;
2. Ongoing monitoring of specific State activities in sampling, review, and corrective action;
3. Re-review of a subsample of State QC case reviews.

This Federal monitoring process will be carried out by Regional Offices of the Health Care Financing Administration.

3150 REFERENCE DOCUMENTS

The Medicaid Quality Control System Manual is comprised of the following sections:

Section 1000 - Administration and Objectives

Section 2000 - Sampling Methods

Section 3000 - The Review Process

Section 4000 - Reports

Section 5000 - Data Analysis

3200 QC REVIEW REQUIREMENTS

Chapter 3200 presents guidelines for the reviewer to follow in conducting all phases of the Medicaid Quality Control review.

3210 DEFINITIONS OF KEY TERMS

3211 Medicaid Beneficiary

An individual who is certified eligible to have payments made from Title XIX funds for specified medical services received during the month(s) or portion(s) thereof covered by the certification.

3212 Case (Sample Unit)

The individual cash beneficiary in the SSI cash assistance population, the family in the AFDC cash assistance population, and, the Medicaid assistance group in the remaining portion of the Medicaid population. A Medicaid assistance group is defined as Medicaid beneficiaries (1) who are eligible for Federal financial participation in the cost of services, and (2) for whom the Medicaid eligibility of each individual was determined based on common financial circumstances.

3213 Review Month

The calendar or fiscal month or portion thereof for which the sampled case, which has been certified eligible for medical assistance, is reviewed.

3220 ROLE OF THE REVIEWER

3221 Reviewer(s) Responsibilities

The QC reviewer(s) is responsible for collecting and verifying all information necessary to determine:

1. The eligibility status of the case as of the review month;

2. Whether third party resources were available to pay for health care services during the review month and whether available funds were appropriately recovered by Medicaid;

3. Whether Medicaid payments for services received during the review month were accurate and in accordance with State policy.

To accomplish the above, each reviewer must have a thorough knowledge of appropriate State Medicaid plan requirements for eligibility, third party liability and claims processing.

3222 Reviewer Activities

The MQC reviewer activities include:

1. Analyzing the case record;
2. Conducting a personal interview with the beneficiary or the beneficiary's representative to determine eligibility and availability of third party resources;
3. Verifying the appropriate elements of eligibility through collateral contacts as required;
4. Recording information on the eligibility worksheets;
5. Making determinations about the eligibility status of the case and each case member;
6. Collecting copies of State paid claims for services delivered during the review month for the case under review;
7. Conducting the third party liability and claims processing reviews;
8. Completing the third party liability and claims processing worksheets;
9. Making determinations about third party liability and claims processing errors;
10. Associating dollar values with eligibility, third party liability, and claims processing errors;
11. Completing the Review Schedule.

The QC reviewer's role does not encompass provision of service. Where individuals bring their service needs to the attention of the reviewer, he should identify the proper unit in the agency to be contacted. At the same time, he should notify the local agency of the request through proper channels.

The above activities must be performed in a manner consistent with the Federal Regulations 42 CFR 406.10 (a) (10) concerning the rights of the beneficiary.

3230 INDEPENDENCE OF THE MQC REVIEW

The MQC reviewer obtains eligibility information from Federal SSI-QA, State AFDC-QC, and local agency case records. The MQC reviewer obtains appropriate documentation of third party investigations from the State third party liability unit and claims for services from State files. Certain other local agency resources may also be used. For example, it is proper to use official processes and program units of the local agency for determining facts and obtaining documentary evidence (e.g., birth certification and property verifications). And, where there is need for additional medical information about a beneficiary's disabilities or incapacity, the reviewer may request that a local agency refer the beneficiary for a physical examination and provide the results of the examination to the reviewer.

The QC review and the reviewer's decision, must be completely independent of the agency that originally determined eligibility. It is improper for a reviewer to question a case worker about what had been done or to accept oral information not contained in the case record. The responsibility for evaluating the information obtained and making a decision remains solely with the MQC reviewer.

State agency QC policies will specify the extent to which and the procedures by which methods such as those cited above are employed. State agency QC policies must conform to requirements stated in this Manual.

3240 DOCUMENTATION OF REVIEWS

The primary forms to be used by the QC reviewer are the eligibility, third party liability, and claims processing worksheets (Subchaps 3480, 3570, 3632), the Verification Guide for Medicaid Eligibility Review (Subchap 3470), and the Review Schedule sections. These forms provide a systematic means for the reviewer to analyze the case record, plan and carry out the field investigation and review, and record findings. The QC review files must contain full documentation for the appropriate elements of each of the worksheets and other information in such detail that the criteria upon which the review decision was based are evident.

3250 RECORD MAINTENANCE

For purposes of Federal review and audit of State Medicaid QC programs, State agencies will maintain their official MQC records in a way that will permit their ready access and use. Official MQC records consist of documents which support State actions in:

1. The Case Selection Process including but not limited to the data and/or working papers used to determine each month's sample frame, interval determination and case selection method, and sample list.

2. The Case Review Process including but not limited to the 301's, 301A's, and 301B's and supporting documents including Federal difference letters for all completed and dropped reviews. States are also required to maintain copies of paid claims for sample cases with their QC records.

3. The Reporting Process including but not limited to all final six-month MQC reports.

Official MQC records must be maintained for a period of three years following the submission of the final six-month report. The records shall be retained beyond the three-year period if audit findings have not been resolved.

3300 ELIGIBILITY QC REVIEW POLICY

This Chapter presents an overview of the Medicaid QC policies that are applicable during the eligibility review.

3310 ELIGIBILITY OVERVIEW

All Medicaid eligible beneficiaries except needy individuals under 21 must meet requirements for categorical relatedness. To be categorically related, a beneficiary must be aged, blind, disabled, or a member of a family with dependent children.

According to Federal Regulations for Medicaid Eligibility (CFR Title 42, Chapter II, Parts 405 and 428), there are both mandatory and optional Medicaid eligibility coverage groups of beneficiaries for which Federal financial participation is available.

All mandatory Medicaid coverage requirements must be met by any State as a prerequisite for approval of the Title XIX State Plan. Mandatory coverage requirements for beneficiaries to be reviewed in Medicaid Eligibility QC are listed in Subchap 3431. At a State's option, Medicaid benefits with Federal financial participation may be extended to additional optional groups of beneficiaries. Any optional coverage requirements for beneficiaries to be reviewed in Medicaid Eligibility QC are listed in Subchaps 3432 and 3433.

There is one optional Medicaid eligibility coverage requirement with no direct categorical relationship: needy individuals under 21 who are financially eligible for Medicaid and in approved classifications (e.g., children in foster care living arrangements, children in low income families, and children in institutions).

Verification of Medicaid eligibility under any of these eligibility coverage requirements must be done in conjunction with approved State plan requirements and Federal guidelines. For the purposes of MQC, State Medicaid eligibility policy is defined as all written policy instructions issued by the State for administering the Medicaid program so long as those instructions are clearly consistent with either the approved State plan or proposed amendments thereto which have been submitted to, but have not been acted upon by the Health Care Financing Administration. Should inconsistencies exist, the provisions of the approved State plan prevail.

3320 DEFINITION OF AN ELIGIBILITY ERROR

There are three types of Medicaid Quality Control eligibility errors. These are:

1. Ineligibility

   Any individual included in a case who is determined as not having met coverage requirements under the State's plan for medical assistance for the review month;

2. Liability Understated

   Any case which had not incurred medical expenses equal to excess income, or resources if State plan permits, prior to being certified eligible for Medicaid or had not applied the proper amount of excess income to incurred medical expenses because of a liability computation error;

3. Liability Overstated

   Any case which incurred medical expenses greater than excess income, or resources if State plan permits prior to being certified eligible for Medicaid or had more than the proper amount of excess income applied to incurred medical expenses because of a liability computation error.

QC procedures recognize the need for an administrative period for States to reflect changes in circumstances. This administrative period covers the month in which the changes first occur and the following month. When the review month is a month within the administrative period, such changes in the medical assistance group's circumstances which are not reflected in the eligibility and liability status of the review month, are not considered to be errors unless the eligibility and/or liability status was in fact adjusted incorrectly as a result of such change. It is to be noted that this administrative period is all encompassing and provides for reporting by the beneficiary, investigation, expiration of notice period, payroll processing, etc. It also encompasses unreported as well as reported changes.

An eligibility error must relate to element(s) or sub-element(s) of eligibility on the worksheets which cause the case to be ineligible or have an incorrect liability amount. There may be only one eligibility error per numbered element or sub-element on the worksheets. Though there may be more than one error per element or sub-element identified in the worksheets, only one eligibility error will be identified as such in the worksheet summary column associated with a number element or sub-element.

3321 Eligibility Errors

An eligibility error during the review month exists when the case or a beneficiary in the case fails to qualify for any Medicaid eligibility coverage specified in the State plan at any time during the review month. For example, total eligibility errors would exist when the case has no categorical relationship during the review month. An eligibility error also exists when a case meets no Medicaid coverage requirement during the review month, when according to a State's eligibility practice, eligibility for a day does not mean eligibility for the entire month.

When an eligibility error is occasioned solely by the failure of case record data as of the review month to reflect changes in an assistance group's circumstances which occurred in the review month (calendar or fiscal) or the month immediately preceding the review month, no case eligibility error will exist (unless the medical assistance eligibility as of the review month was, in fact, adjusted incorrectly). If the eligibility status of the assistance group was incorrect as of the review month and would still be incorrect even disregarding the change in circumstances that occurred in the review month or the month immediately preceding the review month, a case eligibility error exists.

The administrative period will not be applicable to a sampled beneficiary who died before the review month. If there are any claims for services provided to this beneficiary during the review month, report findings to proper investigate authority.

When a beneficiary fails to meet liability as correctly computed prior to Medicaid certification (i.e., he failed to incur the amount of medical expenses computed by the eligibility worker), the beneficiary will not have met State coverage requirements and will, therefore, be ineligible. When liability is met, certification of eligibility is limited to remaining months of the prescribed period. If the review month falls after expiration of this period, the case would be found ineligible.

3322 Liability Errors

3322.1 Liability Errors

A case liability error is determined by comparing the Quality Control reviewer's computation of case's liability with the State agency's similar computation. If the Quality Control reviewer determines that income was undercounted or incurred medical expenses were overcounted, this results in a finding of "case liability understated."

While it is possible that medical expenses not present in agency computations might have been incurred by the case which could be used to demonstrate that case liability has been met, the impractical nature of identifying and verifying additional expenses means that the Quality Control reviewer should not attempt to do so unless appropriate evidence exists in the case record or is provided by case members during the field review.

A finding of "case liability overstated" occurs when the QC reviewer determines that income was overcounted or incurred medical expenses were undercounted. These dollar amounts will be used to compute the dollar amount of eligibility errors.

3322.2 Institutional Case Liability

A liability error also exists when the monthly amount of the beneficiary's liability for institutional care was computed incorrectly. An overstatement exists when the beneficiary was made liable for more than he should have been. An understatement exists when the beneficiary was not made liable for enough of his institutional expense.

3330 QC FINDINGS WHICH ARE NOT ELIGIBILITY ERRORS

There are a number of possible Medicaid Quality Control findings which, although important, are not considered eligibility or liability errors for QC reporting purposes. Such findings are as follows:

1. Suspected provider fraud or abuse;
2. Computation of cost sharing, unless a condition of eligibility;
3. Ineligibility in periods other than the review month;
4. Incorrect agency administrative procedures which do not affect eligibility.

While the information above does not contribute to the MQC findings regarding eligibility of cases during the review month, the information must be referred to the appropriate administrative or program unit for further investigation and subsequent action.

3340 DOLLAR AMOUNT OF A CASE ELIGIBILITY ERROR

The only amount of dollar error computed during the eligibility review phase is the dollar amount of overstated or understated liability. Thus, for purposes of the eligibility review phase:

Type of Error	Dollar Amount of Error
Case is ineligible during part or all of review month	This is a zero dollar amount.
Case eligible during review month with ineligible case members	This is a zero dollar amount.
Case liability understated	The full understated case liability amount.
Case liability overstated	The full overstated case liability amount.

It should be noted that the misspent dollar amount of error cannot be determined during the eligibility review. Associating misspent dollar amounts with these eligibility errors must await collection of paid claims for services rendered during the review month.

For cases with understated or overstated liability errors, the dollar amount of the error is recorded at the completion of the eligibility review.

For reviews which have multiple liability errors, the overall liability dollar amount is the net effect of all applicable errors.

3350 CHANGES IN STATUS WHICH DO NOT RESULT IN AN ELIGIBILITY ERROR

Changes in situations which have occurred since the last agency determination must be evaluated in terms of the specified conditions that exist for the coverage requirement in question as of the review month. For example, an AFDC categorically related beneficiary may have been determined as eligible for Medicaid based in part on deprivation due to the father's absence from the home. The QC reviewer finds the father returned to the home but the deprivation element still exists due to the incapacity of the father as of the review month. Change in the deprivation element does not affect the basic eligibility of the beneficiary under the coverage requirement in question.

3360 CHANGES IN COVERAGE REQUIREMENT WHICH DO NOT RESULT IN AN ELIGIBILITY ERROR

If the beneficiary is determined to be ineligible based on the Medicaid eligibility coverage requirement utilized by the agency, the QC reviewer must determine whether the beneficiary meets all elements related to any other Medicaid eligibility coverage requirement. In other words, even if the beneficiary does not meet the coverage requirement utilized by the agency, eligibility may still exist. If the beneficiary is eligible under a coverage requirement other than that utilized by the agency, the elements for the coverage

requirement under which the beneficiary is eligible should be verified and recorded on the worksheets, and no error should be reported. The investigation of potential eligibility for the review month should be limited to the data furnished by the beneficiary(ies) during the course of a normal field investigation or is available from the case record and collateral sources during a desk review.

3370 REPORTING OF ELIGIBILITY ERRORS

Review findings regarding the beneficiary's eligibility will be promptly reported by suitable means, to the appropriate State or local units for action. These units are expected to follow-up on MQC review information and to take action which is consistent with Federal Medicaid regulations and guidelines.

Interchanges subsequent to the MQC findings fall within usual administrative channels. Actions taken subsequent to the MQC review and their effects on the beneficiary's eligibility and payment status fall outside the scope of MQC.

3380 ACCEPTABLE REASONS FOR DROPPED REVIEWS

It is essential that every effort be made to complete the review of each sampled beneficiary, although some may present difficulties. The inability to contact the beneficiary will not necessarily preclude completion of the review if all relevant elements of eligibility can otherwise be verified within the reporting period. If repeated efforts by the reviewer to obtain cooperation fail, the beneficiary should be visited by another reviewer or assistance from the certifying agency should be requested. The investigation is to be continued to the maximum extent possible. Where verifications can be obtained without assistance from the beneficiary, the review is to be completed.

Incomplete reviews, unless kept to a minimum, may cause the validity of Medicaid QC findings to be questioned. A full recording of the reasons for inability to complete an investigation will be entered on the worksheets. However, all reviews must be completed (reviewed to a definitive conclusion) when the verifications of elements of eligibility are within the control of the State agency. Review Schedules are to be completed for all dropped reviews through Item O.

3381 Beneficiary Will Not Cooperate

When needed documentation cannot be obtained without the cooperation of the beneficiary, the review may be dropped. For these reviews, the reviewer will notify the local agency that the beneficiaries would not assist in substantiating their eligibility and payment status.

3382 Beneficiary Cannot Be Located

All reasonable efforts will be made to locate a beneficiary who is assigned for review. No beneficiary is to be classified as "unable to locate" when only a single visit has been made to the address. The aid of the local agency, relatives, businesses, postal authorities, employers, and other sources may be necessary in the attempt to locate. Only when all reasonable resources for location have failed will the review be dropped. The local agency will be notified of such beneficiaries so that proper action can be taken. The worksheets will show the steps taken in trying to locate the beneficiary.

The temporary out of State absence of the beneficiary will not preclude completion of the review unless the absence extends beyond the time when the review must be completed for the current reporting period. If the absence can be verified as temporary and documentation can be obtained for appropriate elements of eligibility, the review is to be completed without the personal interview. In instances of extended absence, the review should not be completed and the reason noted on the review schedule.

3383 Beneficiary Moved Out Of State

If the beneficiary has moved out of State since the review month, and the review could not be completed without an interview. However, if the beneficiary resided out of State as of the review month, all efforts must be made to complete the review.

3384 Listed In Error

If a case is determined to have been sampled in error, the review will not be completed. For example, the SSI-QA sampled beneficiary in a non-1634 State is not included in the State's Medicaid eligibility file.

3385 Other

Before dropping a review for any reason besides those already discussed, the QC reviewer should obtain supervisory approval. An example of an other acceptable basis for dropping a review would be if the beneficiary's Medicaid eligibility was being continued based on an appeal from a proposed termination.

3390 UNACCEPTABLE REASONS FOR DROPPED REVIEWS

Some unacceptable reasons for dropped reviews are included on the following page.

3391 Action To Terminate Occurred Prior To The Review Month

If a local agency action to terminate a beneficiary commenced, but was not completed, prior to the review month, the review must be completed.

3392 Cases In Which Eligibility Terminated Since Review Month

The fact that eligibility may have been terminated after the review month but prior to the QC reviewer's interview does not obviate the need for the review. Every effort will be made to enlist the beneficiary's cooperation in completing the review.

3393 Cases Of Suspected Beneficiary Fraud

When there appears to have been willful misrepresentation of facts in the application for Medicaid, the failure to report a change in circumstances, the use of an invalid Medicaid card, or the use of a valid Medicaid card by an unauthorized beneficiary, the QC review shall be completed. The appropriate investigatory agency should be notified.

3394 Cases In Which There Is No Evidence Of Medicaid Eligibility Certification

When the reviewer cannot verify from agency case records that an appropriate Medicaid eligibility determination was made by the agency for a beneficiary prior to the review month, an ineligibility error (element 540, nature 80, type 60) will be recorded and the case referred to the appropriate investigative authority.

3400 ELIGIBILITY QC REVIEW PROCESS

3410 PURPOSE OF THE ELIGIBILITY QC REVIEW PROCESS

The eligibility QC review process serves two major purposes. These are as follows:

1. To determine for the review month that the beneficiary(ies) qualifies for Medicaid through meeting all elements of eligibility related to an eligibility coverage requirement specified in the State plan;

2. To identify potential payment resources (third party resources) other than Medicaid that may be obligated to pay for services delivered during the review month.

3420 APPROACH TO MQC ELIGIBILITY DETERMINATION AND IDENTIFICATION OF THIRD PARTY RESOURCES

The QC reviewer must determine for the review month that all members of a Medical Assistance Group qualify for Medicaid through meeting all elements of eligibility related to an eligibility coverage requirement specified in the State plan. The multiple number of eligibility coverage requirements that exist for a State program mean that different eligibility elements and, therefore, verification requirements will apply for individual beneficiaries.

In addition, the QC reviewer should determine whether medical services received during the review month might be covered by a payment source other than Medicaid.

3421 Approach To Eligibility MQC

The major steps in the eligibility QC review process, whether the beneficiary is AFDC categorically related, SSI categorically related, a needy individual under 21, or receives cash payments, are:

1. Determine if the beneficiary is eligible under all elements required for the indicated coverage requirement as of the review month, and if not;

2. Determine if the beneficiary is eligible under all elements required for any other appropriate coverage requirement included in the State plan as of the review month, then;

3. When applicable, determine whether there is liability that must be met;

4. When applicable, determine if liability was correctly met prior to being certified eligible for Medicaid;

5. When applicable, determine if the monthly amount of the beneficiary's liability for institutional care was computed correctly;

6. Determine the type of eligibility error(s) and dollar amount of liability errors.

To determine whether or not a beneficiary is eligible under any of the State's prescribed beneficiary classifications, the reviewer must conduct an investigation of the beneficiary's circumstances which affect eligibility in the review month.

The MQC reviewer must independently establish and verify the information about pertinent elements of eligibility in order to arrive at a definitive conclusion on eligibility and beneficiary liability, if applicable, as of the review month.

If the sampled case includes more than one member, the circumstances of all members of the Medicaid Assistance Group will have to be reviewed. If the review indicates all members are ineligible due to applying common financial eligibility factors, the individual members may still be eligible in his or her own right. For MQC purposes, the reviewer will determine if any beneficiary(ies) is otherwise eligible, this finding will result in a review determination "Case eligible with ineligible members".

The eligibility QC review process is applied to the following general types of cases. Specific case types and coverage codes are given in a subsequent section.

1. Cases found ineligible through the AFDC-QC process;

2. Cases found ineligible through the SSI-QA process and cases found eligible by SSI-QA that require screening against more stringent State criteria (209B/ States);

3. All cases drawn for the Medicaid sample (includes mandatory and optional categorically needy AFDC- and SSI-related cases, and other optional Medical Assistance Groups).

Each of these cases must be checked to determine if the beneficiary(ies) is eligible under any Medicaid coverage requirement in the State plan.

MQC review of cases found ineligible through the AFDC-QC and SSI-QA are subjected to a review to determine their eligibility under any Medicaid coverage requirement. This includes a QC or QA case file review and telephone contacts to verify elements of eligibility. A follow-up field investigation should be undertaken only if the information thus obtained is inconclusive.

All cases from the Medical Assistance Only sample must be subject to a full investigation, which includes a review of the case record, an interview with the beneficiary or the beneficiary's representative, and an appropriate field investigation.

3422 Approach To Identification Of Third Party Payment Resources

During the case record review and field investigation, a QC reviewer must seek to identify potential third party payment resources for services received by the beneficiary during the review month. Acquisition of potential third party liability information during the eligibility review is essential to subsequent determination of whether Medicaid paid for and did not subsequently recover funds for services for which a health insurance company, other Government financing program, or individual was liable. Chapter 3500 describes the relevant types of potential third party resources which will be subject to review and the review process.

Three general TPL information areas are included in the eligibility QC process. The first is identification of third party resources for health services in a non-casualty situation, for example, coverage by a private health insurance policy of in-patient hospital stays (e.g., Blue Cross/Blue Shield coverage for an appendectomy). Other examples of liable third parties in non-casualty situations are Medicare, CHAMPUS and medical support by an absent parent. The second area of investigation is identification of accidents that occurred prior to or during the review month for which services related to the accident were received during the review month. When accidents are identified, potential third party liability through automobile insurance, Workmen's Compensation and other types of liability insurance may be available. The third area of investigation,

inquiry into services received by case members during the review month, serves several purposes. It identifies those cases for which claims can be expected, it provides a means of inquiry into potential TPL casualty situations and it provides an indication of whether all claims for a case have been collected by the end of the review period.

The process for identification of potential third party resources is integrated into the eligibility review instructions comprising the remainder of Chapter 3400. Components of the Verification Guide, Worksheets and Verification Requirements include the information required for eligibility QC review and identification of potential third party resources.

3430 CASES TO BE REVIEWED

Cases to be reviewed using the Medicaid Quality Control process are selected from the State universe of medical assistance groups that were certified as Medicaid eligible for the review month by a Federal (SSA), State or local agency. In all sampled cases subject to an eligibility review, the eligibility of each member of the case must be reviewed.

The groups covered by Medicaid are listed in the Verification Guide (Subchap 3470), and, for each group, a coverage code is given. The Verification Guide specifies the elements of eligibility that must be verified in the various coverage groups and the third party information that must be collected. The coverage codes are then used to identify case types on the Review Schedule. This type of coding allows the State to develop profiles of errors, by case type, which may be useful for developing corrective action.

3431 Case Coverage Exceptions

The designation "SSI related" as used in this Manual is not relevant in the Adult programs in Guam, Puerto Rico and the Virgin Islands. In the MQC Manual the substitution of the word Adult for SSI where there is reference to the SSI categorical relationship will generally make the Manual applicable in these jurisdictions. Specifically, when used in Guam, Puerto Rico and the Virgin Islands, the following interpretations shall prevail when appropriate in the Verification Guide:

1. Substitute "Adult" wherever "SSI" appears.
2. Coverage codes: 01, 02, 03, 21, 22, 24, are not applicable.
3. References to SSI financial standards, deductions and other eligibility criteria are not applicable; substitute Title I, X, XIV or XVI related ME criteria.

4. References to beneficiaries who receive SSI basic payments and beneficiaries who receive mandatory State supplementary payments only, are not applicable.

3440 CASE RECORD REVIEW

The case record review includes (1) analyzing the case record of the eligibility unit and (2) completing the facesheet and case record sections of the worksheets. AFDC-QC and SSI-QA worksheets may be used in lieu of, or in addition to, MQC worksheets as appropriate to provide requisite back-up to the Medicaid Quality Control review findings. Through analysis of the case record, the reviewer familiarizes himself with the case circumstances, identifies the information related to the Medicaid eligibility coverage classification under which the beneficiary may qualify and notes gaps or deficiencies in information. Where documents or statements are contained in the record, the QC reviewer will identify those which may be used as verification. Examples of such documents or statements are: (1) official documents or reports, (2) certified or reproduced copies of official documents or reports, and (3) full recording by a person who has obtained information directly from public or other records. In order for record material to be accepted as verification, it must contain specific information such as volume and page references to public refords. This information must be recorded on the worksheet.

Every effort must be made to locate and analyze the beneficiary's case record. However, if the case record cannot be located, the review must still be completed through the beneficiary interview and collateral contacts. In Subchap 3394, the single exception, no evidence of Medicaid eligibility certification, is discussed.

3441 Facesheet Completion

The documentation requirements for individual case Medicaid Quality Control reviews include a facesheet for identification and control information, worksheets for documenting findings on each review and a beneficiary liability worksheet to be used as required.

The facesheet, shown as Exhibit 3400-1, provides for entering identifying information about the case. Most of the information necessary to complete the facesheet will ordinarily be found in the case record.

Prior to completing sections A, B, and C of the facesheet, the QC reviewer should check the appropriate box on the top of the facesheet to indicate whether the review is being completed for an AFDC related case, an SSI related case, a needy individual under 21, an AFDC case or an SSI case. Instructions for completing each section of the facesheet are given on the following pages.

Section A: Identifying Information

1. Agency - Enter name of local agency.

2. Case number - Enter the number used by the State Medicaid agency to identify the case.

3. MQC Review number - Enter the serial number assigned to this case (supplied to the reviewer by the State Office).

4. Case name - Enter the beneficiary's name or the full name of the head of the Medical Assistance Group, whichever is applicable

5. Address - Enter the complete address of the Medical Assistance Group.

6. Telephone number - Enter the telephone number for contacting the beneficiary or head of household of the Medical Assistance Group, whichever is applicable.

7. Date and type of most recent opening, re-opening, or recertification - Enter the most recent month and year in which eligibility was determined or redetermined.

   Approved application (new or reopened case) - Approval means the agency's decision to certify eligibility.

   Redetermination or recertification - Redetermination or recertification means (a) a complete re-examination by the agency of all factors of eligibility subject to change following a period of time during which the beneficiary(ies) had been determined eligible, and (b) a decision was made to continue eligibility.

8. Directions to locate - Enter, if needed and available in the record, the directions to the residence.

9. Other information - Enter any other information about the case that the reviewer may need to use in the field investigation. This may include date of home visit, language barriers, etc.

The following information may be utilized by the QC Unit for control purposes.

10. Review month - The review date (month, day, year) is the month for which the reviewer will determine the eligibility and liability status of the case. The review date will be furnished to the reviewer by the State Office.

11. Date assigned - Enter the date on which the case was assigned for review.

12. Date of case reading - Enter the date on which the case record was reviewed to determine the case circumstances and information required to be verified in the field investigation.

13. Date of interview - Enter the date on which a personal interview was held.

14. Date eligibility review was completed - Enter the date on which the QC reviewer's determination was made as to the eligibility and liability status of the case member(s).

15. Reviewer - Enter the name of the person completing the review.

Section B: Members of the Household

Name - Enter in this column the name of all persons living in the household. A household includes all persons including unborn children of pregnant members of the household (if included in State plan) who occupy a group of rooms or a single room which constitutes a housing unit.

A housing unit is defined as a group of rooms or a single room occupied as separate living quarters, that is, when the occupants do not live and eat with any other persons in the structure, and where there is either (1) direct access from outside of the building or through a common hall or (2) complete kitchen facilities for the exclu-

Form HCFA-301 A (3/78)
Department of Health, Education and Welfare
Health Care Financing Administration

MEDICAID QUALITY CONTROL
FACESHEET

OMB No. 066-R-0107
Expires 3/79

Form Completed for: AFDC Related Case ☐ AFDC Case ☐ SSI Related Case ☐ SSI Case ☐ Needy Individual Under 21 ☐

A. IDENTIFYING INFORMATION

1. Agency
2. Case Number
3. QC Review Number
4. Case Name
5. Address
6. Telephone Number
7. Date/Type of most recent opening, re-opening or recertification:
   Date _____
   Type
8. Directions to Locate
9. Other Information
10. Review Month
11. Date Assigned
12. Date of Case Reading
13. Date of Interview
14. Date Eligibility Review Completed
15. Reviewer

B. MEMBERS OF THE HOUSEHOLD

	Name	Birthdate	Relationship or Significance	Social Security Number	Medicaid Eligibility Pertinent	Sanctioned Member	Eligibility Status Code
1.							
2.							
3.							
4.							
5.							
6.							
7.							
8.							
9.							
10.							

C. SIGNIFICANT PERSONS NOT IN HOUSEHOLD

	Name	Age	Relationship or Significance	Social Security Number	Address
1.					
2.					
3.					
4.					

D. ELIGIBILITY REVIEW FINDINGS

1a. Case Status
(1) Eligible ☐ 54
(2) Ineligible
(3) Eligible w/Ineligible Members
(4) Liability Understated Error Only
(5) Liability Overstated Error Only
(6) Liability Understated Error w/Ineligible Member(s)
(7) Liability Overstated Error w/Ineligible Member(s)

1b. Case Member Status
(1) Eligible Members — Number 55 56
(2) Ineligible Members — 57 58
(3) Eligible Members w/Understated Liability — 59 60
(4) Eligible Members w/Overstated Liability — 61 62

2. Number of Elements in Error — 63 64

3. Dollar Amount of Liability Errors — 65 66 67 68 69

EXHIBIT 3400-1

sive use of the occupants of the household. These would include the beneficiary, and both related and unrelated persons, including roomers and boarders. This section provides the reviewer with information which will help him recognize persons whom he may encounter during the home visit and understand their role in the household. If additional space is needed, use the reverse side of the facesheet.

Birthdate - Enter in this column the birthdates of all related persons (and unrelated persons, if known) listed as members of the household.

Relationship or significance - Enter in this column the letters, such as SP (spouse), S (son), D (daughter), GS (grandson), N (niece), or FR (friend), etc., to show relationship of the household members. If any household members receive AFDC or SSI cash assistance, enter their category and case number also in this column.

Social security number - Enter in this column the social security number of each household member, if known. Enter "Unknown" if the number cannot be determined from the case record of field investigation. Enter "None" if it is known that the household member never had a social security number.

Medicaid beneficiary(ies)- For each person listed as a member of the household, check (✓) this column if the person is certified eligible for Medicaid as part of the Medical Assistance Group. A Medical Assistance Group is comprised of Medicaid beneficiaries (1) who are eligible for Federal financial participation in the cost of Medicaid services, and (2) for whom Medicaid eligibility was determined based on common financial circumstances. If there are persons in the household who are certified eligible for Medicaid, but are not included in the beneficiary's Medical Assistance Group, enter an asterisk (*) for those beneficiaries.

Services received - For each person certified eligible for Medicaid as part of the Medical Assistance Group, enter an (X) for those beneficiaries who stated during the field investigation that they received services during the review month.

Eligibility status - For each person determined to be eligible by the MQC reviewer, enter an "E" in this column. For each person determined to be eligible for only part of the review month, enter a "P" in this column. For each person determined to be ineligible enter an "I".

Section C: Significant Persons Not In Beneficiary's Household

Name - Enter in this column the names of other persons and responsible relatives not in the household, living or dead, who are of significance to the circumstances of the household. This includes all absent parents (and alleged parents) of children in the household, deceased spouses, and separated spouses. For institutionalized beneficiaries enter the names of caretaker relatives and/or legal guardian.

Age - Enter in this column the age, if known, of each person listed in this section. The approximate age may be used, if no method of verification is available.

Relationship or significance - Enter in this column the relationship of each person listed to the head of the household, using the same abbreviations as in the instructions to Section B.

Social security number - Enter in this column the social security number of persons listed in this section if known. Enter "Unknown" if the number cannot be determined from the case record or field investigation. Enter "None" if it is known that the significant person(s) never had a social security number.

Address - Enter in this column the address of each person listed. If the address cannot be determined from the case record or field investigation, enter "Unknown".

Section D: Eligibility Review Findings

Although similar information is recorded on the Review Schedule, this section provides for a brief summary of eligibility review findings. These are:

1.a. Case Status - Enter number in box which corresponds to eligibility status of the case. This entry corresponds to entry for item Q of

the Review Schedule.

1.b. Case Member Status - Enter number of case members which fall in each category. The sum of these numbers must equal the total number of case members. When only a case liability error exists, (3) or (4) must have an entry and (1) must indicate [0|0]. Always enter a two digit number, e.g., [0|0], [0|1]. This entry corresponds to entry for item Q of the Review Schedule.

2. Number of Elements in Error - Enter the total number of elements in error identified in the review. If the same element is in error for more than one case member, it will only be counted as one element in error.

3. Dollar Amount of Errors - Enter the overall dollar amount of overstated or understated liability. This dollar amount corresponds with entries in item R of the Review Schedule.

3442 Case Record Review: Eligibility

The case record review for eligibility QC assists the reviewer in planning and focusing the field investigation by providing some recorded information which will not need reverification during the field investigation.

The complete set of worksheets for use during the eligibility QC review are displayed in Subchap 3480. In Exhibit 3400-2 following this page, the first page of the basic eligibility worksheets is shown. Each page of these worksheets has six (6) column headings. The first column lists the elements of eligibility known to be common prerequisites for Medicaid eligibility in most State plans. The second column should be completed based on extracting eligibility and other information during the case record review. The third column on the worksheets is for documentation of the findings of the field investigation; while the fourth, fifth, and sixth columns provide a summary for eligibility error measurement.

In order to complete column two (2) of the worksheets, which records findings from the case record review, the reviewer should follow the procedures listed below.

1. Using the coverage group assigned by the State to the sample case, identify (using the Verification Guide in Subchap 3470) the elements of eligibility that must be reviewed for that case.

2. Refer to Subchap 3460 which lists the sources of verification by eligibility element to

EXHIBIT 3400-2
MEDICAID QUALITY CONTROL WORKSHEET:
ELIGIBILITY AND TPL IDENTIFICATION

Review No._____

ELEMENTS OF ELIGIBILITY DETERMINATION	QC ANALYSIS OF CASE RECORD (Pertinent Facts, Sources of Verification, Reliability, Gaps, or Deficiencies)	FINDINGS OF FIELD INVESTIGATION (Facts Obtained, Verification and Substantiation, Nature of Errors)	SUMMARY (Check One)			ELEMENT CODE
			No Error/ Not Applicable	Error		
				Agency	Beneficiary	
(1)	(2)	(3)	(4)	(5)	(6)	
	BASIC PROGRAM REQUIREMENTS (100)					
110 Age						110
120 Citizenship/Alienage						120
130 Residency						130
140 Living Arrangement (Include institutionalization and living with specified relative)						140

determine the eligibility information that should be extracted from the case record.

3. Review the case record and record in column two (2) of the worksheets any pertinent facts. Record information which will not need reverification and record facts, methods or conclusions that are under question. Also, record conflicts in information contained in the case record, factors needing reverification because they are subject to change, reliability of sources appearing in the case record and gaps in information. Record information needed for the Review Schedule (Subchap 3490).

4. Use column two (2) of the worksheet to highlight points for consideration in the field or to enter information that will serve to remind the reviewer of the beneficiary's situation.

5. If the case or any individual member(s) does not appear to be eligible under the coverage category specified by the State, the reviewer should examine the case record to determine other possible eligibility.

With the exception of SSI cases where eligibility is determined using State criteria more stringent than those of SSI, AFDC and SSI cash payment, cases may, at State option, be assigned to Medicaid QC review only when they have been found ineligible by AFDC-QC or SSI-QA review. Therefore, MQC review of these cases should address only eligibility under any other Medicaid coverage category; these cases should not be re-reviewed for eligibility for cash payments. The MQC review for these cases should include a QC or QA case file review with telephone inquiries to verify elements of eligibility. A full field investigation must be conducted when no conclusive eligibility determination can be made through the desk review or when the State elects to conduct an independent review of the SSI population.

3443 Case Record Review: Identification Of Potential Third Party Liability

The case record examination must include review for potential third party liability (TPL). The purpose of this segment of the review is to identify a record of health insurance that may be available to the beneficiary(ies) during the review month. In addition, the case record may contain information suggesting the occurrence of an accident or casualty situation. In these cases,

a current or previous employer, insurance company or individual may be liable for payment of medical expenses for an injury or disabling condition associated with the accident.

In Chapter 3500 of this Manual, descriptions of a variety of potential third party resources are given. Before conducting case file reviews, the QC reviewer should become familiar with these third party resources and the populations to whom they are most likely to apply. For example, if a beneficiary or head of a household is recently unemployed, the reviewer should examine the case record for group health insurance coverage that may continue for a period after termination of employment or for which the beneficiary is now paying the monthly premiums. Alternatively, the case record may indicate that employment was terminated due to a work-related or other accident. Third party payment for medical care associated with this accident may be available through a Workmen's Compensation carrier or through other liability insurance.

In addition to the above, evidence of potential third party liability that may be encountered in the case file review includes the following:

1. Legal documents, in absent parent cases, indicating medical support requirements;

2. Evidence of current or previous service in the U.S. Armed Forces by a member of the case or family or an absent parent which may indicate availability of CHAMPUS or other Veterans' benefits to some or all members of the Medical Assistance Group;

3. Evidence of a previous accident (automobile or other) that may have been sufficiently serious to warrant medical services during the review month;

4. Evidence that an individual applied for Medical Assistance due to incurred medical expenses for treatment of injuries or conditions resulting from an accident;

5. Any record of group or individual health insurance that may still be available to cover a beneficiary's medical services.

Information from the case file on potential third party liability is to be recorded in Element 240, Column two (2) of the work-

sheets (Subchap 3480). The specific facts to be extracted from the case record are listed in Subchap 3460. To summarize from Subchap 3460, essential information in the case of private or governmental health insurance includes the insurance carrier or government program and identification of the insurance policy and the insured; i.e., group and policy holder, beneficiary name and policy numbers. If the case record review reveals a casualty situation that may need further investigation, the reviewer should record the circumstances of the accident and injuries sustained to be used to guide the field interviews.

During the case record review, all cases received from AFDC-QC and SSI-QA should be examined for completeness of third party liability information. If a conclusive decision regarding the availability of any third party coverage cannot be made, the QC reviewer should make telephone inquiries to ascertain availability of third party liability.

It will not be possible during the case record review or field investigation to determine whether identified third party resources can be applied to specific services received by the beneficiary in the review month. This can only be determined after specific claims for services are collected.

Review of the case record for potential TPL will serve as a guide in planning the field investigation. However, if no evidence of potential third party liability appears in the case record, the reviewer cannot assume that no third party resources exist. This area of questioning should always be included in field interviews for non-cash payment beneficiaries regardless of the information or lack of information in the case record.

3450 FIELD INVESTIGATION

Once the case record review is completed, the reviewer must conduct a field investigation in order to document and verify all elements affecting eligibility and payment status during the review month. The field investigation is pursued to the point that conclusive findings on eligibility and beneficiary liability can be made according to appropriate Medicaid coverage requirements. The field investigation also serves as a source of information on potential third party liability.

The full field investigation includes interviews with the beneficiary(ies) (or someone acting in their behalf such as a parent, spouse or legal guardian), contact with collateral sources of information, correspondence, review of documents, telephone coversation, and/or any other activity which is pertinent to the review.

The factual results of the field investigation as they relate to each program area are recorded in Column 3 of the Worksheets. Any questions raised in the case record review and shown in Column 2 should be answered during the field investigation.

3451 Personal Interview

As a rule, the interview will be held in the home (unless a beneficiary is institutionalized) or requests that it be held elsewhere. When the interview is not held in the home, the reviewer will need to provide beneficiaries with advance notice on what will be needed in the interview to establish eligibility and identify potential third party liability.

The MQC interview should not be structured or directed in such a manner as to preclude a beneficiary's active participation. The reviewer should make clear to beneficiaries the purpose of the interview and cover relevant topics in a manner which permits the beneficiary to discuss each topic fully.

The interview is focused on:

1. Establishment of identity and categorical relationship of all members of the Medicaid assistance group as required.

2. Discussion of each relevant element of eligibility for the purpose of:

   a. Obtaining statements, reviewing whatever documentary evidence is available from the beneficiaries, and/or securing leads to appropriate evidence in relation to eligibility.

   b. Ensuring that all significant aspects of eligibility have been thoroughly explored, and ascertaining whether there have been changes in the situation in relation to elements of eligibility which are relevant to the review month.

3. Identification of potential third party liability through questions about private health insurance coverage, coverage by other government programs, medical support by absent parents, and the occurrence of accidents for which third parties may be liable for associated medical expenses.

4. Discussion and documentation of medical services received in the review month.

It is important to note that there will be instances when it may not be practical to personally interview a beneficiary. When the only beneficiary is a child, the personal interview may be conducted with the parent or caretaker relative of the child. If the beneficiary is physically unable to participate in an interview, the interview will be conducted with a relative or representative. If there are two parents of an AFDC categorically related beneficiary, it is not necessary to interview both if one parent can, to the reviewer's satisfaction, provide necessary information about the Medicaid assistance group. Also, it is not necessary to interview both members of an SSI categorically related couple.

In addition, a personal interview is not required for certain beneficiaries in nursing homes or medical facilities. The interview may be modified or eliminated when (1) the beneficiary's health or recovery will be negatively affected or (2) the beneficiary is not able to provide accurate or useful information. In these cases, the reviewer will rely on collateral sources of information such as relatives or representatives of the institution.

The conduct of personal interviews is guided by the following:

1. The Verification Guide (Subchap 3470) which indicates the elements of eligibility that must be verified for each Medicaid coverage category;

2. The Information and Verification Requirements by Element (Subchap 3460) which lists the specific information and documentation required and potential sources for verifying each element of eligibility and potential third party liability;

3. The questions arising from the reviewer's examination of the case file.

The procedures for conducting personal interviews are as follows:

1. Review unverified elements and information gaps as identified through comparison of case record findings to the information required as specified by the Verification Guide and Verification Requirements by Element. Record notes for the interview on Worksheets.

2. Contact and schedule an interview with a beneficiary or other appropriate individual. Explain purpose of interview and information requirements to the individual to be interviewed.

3. Conduct personal interview according to information needs defined in Step 1. Obtain consent for collateral contacts and authorization for release of medical information.

4. Complete Column 3 of Worksheets to document any verification of elements occurring during the personal interview.

5. Note elements which require further investigation through collateral contacts.

6. Complete sections of the Review Schedule (as shown in Subchap 3490) which are appropriate for the sampled case.

3452 Collateral Contacts

The reviewer will discuss the need for additional information and make every effort to enlist the beneficiary's cooperation and participation in the identification and selection of the best sources of information. For institutionalized beneficiaries, contact with administrative personnel of the institution is normally required.

If at all possible, the reviewer will obtain the beneficiary's or his representative's consent for contacting collateral sources for information essential to determining eligibility, even if he has given his consent previously.

Where the beneficiary or his representative refuses to give consent for collateral contacts, the reviewer will nevertheless contact collateral sources, to the extent possible, if this is necessary to arrive at a definitive decision on eligibility. Even where the beneficiary requests that his eligibility be terminated, the investigation will be continued to the fullest extent possible. In such instances, the beneficiary will be advised by the reviewer that the investigation will be pursued and that certain collateral contacts will be made by the reviewer.

The Information and Verification Requirements by Element (Subchap 3460) provide possible collateral contacts for verifying each appropriate element of eligibility.

3460 INFORMATION AND VERIFICATION REQUIREMENTS BY ELEMENT

This Chapter provides the reviewer with sources for verification of elements of eligibility and instructions for investigating potential third party liability (TPL). The sources of verification, listed in order of priority, are generally acceptable for the QC elements of eligibility discussed in this section. The listings are not all inclusive for the individual elements, nor will they apply equally to all beneficiary situations. Verification instructions are listed separately for information available from the beneficiary and information available from other sources.

The QC reviewer will, in a given situation, evaluate the beneficiary circumstances and selectively determine which available verification source(s) meets the needs for the eligibility elements which are relevant to the review.

The eligibility elements are discussed under five main groupings called program areas, and are numbered to correspond to the related Review Schedule codes. For each element discussed, it is indicated whether the element is to be verified for SSI related beneficiaries, AFDC related beneficiaries, needy individuals under 21, or a combination of the above.

One of the eligibility elements, Medical Insurance, is expanded beyond eligibility to specify the information required for TPL review. In situations where Medical Insurance is relevant to eligibility certification, the Medical Insurance element (240) will serve two purposes. In situations where Medical Insurance is not relevant to the eligibility determination, this element will be used solely as a guide for investigating potential TPL. TPL elements for identification of casualty situations and beneficiary services during the review month are also included in element (240).

The eligibility elements within each of the five program areas are as follows:

100 Basic Program Requirements

Age
Citizenship/alienage
Residency
Living arrangement
Deprivation - Death
Deprivation - Incapacity
Deprivation - Continued absence
Deprivation - Unemployed father
Blindness/disability determination
Marital status
Other categorical relationship requirements

200 Resources

Real property
Liquid assets - Cash on hand
Liquid assets - Bank accounts
Liquid assets - Stocks and bonds
Liquid assets - Other
Life insurance
Medical insurance
Medical services in the review month
Accident related third party liability
Other personal property
Disposal of property

300 Income

Earned income
RSDI benefits
Veterans benefits
Unemployment compensation
Workman's compensation
SSI
Other
Pensions or other benefits
Support payments
Income, in-kind or deemed
Other income

400 Computations Of Financial Eligibility

Computations of income
Deductions to computable income
Arithmetic computation
Beneficiary liability determination

500 Other Medicaid Coverage Requirements

AFDC related budgetary allowances
AFDC special needs - Child care
AFDC special needs - Transportation
AFDC special needs - Work expenses
AFDC special needs - Personal care
AFDC special needs - Other
Grandfathered coverage provisions
Other State Medicaid criteria

The investigative methods and sources of verification, organized by program area, are on the following pages.

3461 Basic Program Requirements (100)

110 AGE - This element must be verified for all beneficiaries reviewed except for SSI related beneficiaries whose basis for Medicaid eligibility is blindness or disability.

Where age is a factor of eligibility, the reviewer will establish whether the beneficiary is within the age limit prescribed by State policy and verify the age.

The birth certificate is the primary verification to establish age. If a birth certificate is not available, other sources of verification will be used.

a. Verification Information Generally Available From The Beneficiary

1. Birth Certificate
2. Baptismal Certificate
3. Confirmation Papers
4. Military Service Papers
5. Immigration Papers
6. Naturalization Papers
7. Hospital Birth Certificate
8. Adoption Record
9. Passport
10. Voter Registration Card
11. Family Bible
12. Marriage License
13. Driver's License
14. State or Federal Census Record
15. Liquor Control Board Age Card
16. Employment ID Card
17. Life Insurance Policy

b. Verification Information From Other Sources

1. State Bureau of Vital Statistics or Department of Health
2. Baptismal Record of Church
3. Hospital Records
4. School Records
5. Immigration Records
6. Naturalization Records
7. Church Records
8. Marriage Record
9. Physician's Records
10. Draft Board Records
11. Military Service Record

12. Confirmation Record
13. Voter Registration Records
14. Vaccination Record
15. Midwife's Record of Birth
16. Alien Registration Card
17. Insurance Company Records
18. Employer's Records
19. Labor Union Records

120 CITIZEN/ALIENAGE - This element must be verified for all beneficiaries reviewed.

A Medicaid beneficiary must be a citizen, legal alien, or legal alien under color of law to qualify for Medicaid coverage. The definition of aliens permanently residing under color of law is contained in Section 203(a)(7) and Section 212(d)(5) of the Immigration and Nationality Act. In addition, SSA has lists of persons arriving in the United States prior to 1948. Also, certain Medicare benefits such as the Prouty benefits are only available to citizens and legal aliens. The reviewer will establish citizenship or alienage in accordance with State plan requirements.

a. Verification Information Generally Available From The Beneficiary

1. Birth Certificate
2. U.S. Passport
3. Certificate of Citizenship
4. Consular Report of Birth
5. Certificate of Naturalization
6. Alien Registration Receipt
7. Immigration and Naturalization Form I-94

b. Verification Information From Other Sources

1. Property Records
2. Birth Records
3. Immigration and Naturalization Service
4. Census Records

130 RESIDENCY - This element must be verified for all beneficiaries reviewed.

A Medicaid beneficiary must be a resident of the State during the review month. The only exception to this requirement is if the beneficiary is institutionalized out of State, but covered by Medicaid.

The reviewer will establish residency in accordance with State plan provisions.

a. Verification Information Generally Available From The Beneficiary

1. Property Ownership Records
2. Rental Receipts

b. Verification Information From Other Sources

1. Local Telephone Directory
2. Voter Registration Records
3. Property Ownership Records
4. Local Post Office Records

140 LIVING ARRANGEMENT - This element must be verified for all beneficiaries reviewed.

Verification of living arrangement must be conducted in accordance with State plan requirements.

For AFDC related beneficiaries, this element encompasses two related, yet different components: (1) the degree of relationship, and (2) living with the specified relative. The reviewer will verify whether the relationship between the child and the relative was within the degree specified by the State agency and whether the child was "living with" the designated relative as defined in the State plan as of the review month.

The primary verification for relationship is the birth certificate. For a school-age child, the basic verification to establish "living with" will be school records showing address of the child and relative responsible for the child. For a

pre-school child, the reviewer will have to utilize verification from other sources based on the individual situation.

Source of verification for AFDC related beneficiaries are as follows:

a. Verification Information Generally Available From The Beneficiary

1. Birth Certificate
2. Adoption Papers
3. Baptismal Certificate
4. Marriage Certificate
5. Court Order Record

b. Verification Information From Other Sources

1. Contact with School System
2. Hospital and Clinic Records
3. Landlord's Statement
4. Contact with Public Housing Authority
5. Court Support Order
6. Neighbor's Statement
7. Physician's Statement
8. Juvenile Court Records
9. Child Welfare Records
10. Voluntary Social Service Agencies
11. Community Organizations
12. Church Records
13. Minister's Statement
14. Head Start Records
15. Day Care Center Records
16. Bureau of Vital Statistics
17. Visual Confirmation
18. Insurance Policy

If Medicaid eligibility for an SSI related beneficiary is based on institutionalization, the QC reviewer must verify that the beneficiary was institutionalized as of the review month.

If Medicaid eligibility for an SSI related beneficiary is based on potential eligibility for SSI, living arrangement is important in that it establishes the Standard Payment Amount (SPA) for computation purposes. The SPA to which income and adjustments are applied in arriving at SSI benefits differs for the types of living arrangements listed on the following page.

- Living In Own Household (Full SPA). Also included under this item is a child in the household of a parent, a resident of a private institution for whom Medicaid covers no more than 50% of the costs, and a resident of a commercial establishment.

- Living In Household Of Another (SPA reduced by one-third).

- Living In Public Institution And Medicaid Covers 50% Or Less Of Costs (SPA reduced to 0).

- Living In Public Or Private Institution, Medicaid Covers More Than 50% Of Costs (SPA reduced to $25).

The requirements for each of these living arrangements are recorded in the SSI Claims Manual.

Sources of verification for SSI related beneficiaries:

a. Verification Information Generally Available From The Beneficiary

1. Institutional Records
2. Rent Receipt
3. Deeds
4. Property Tax Receipts
5. Receipts for Household Expenses

b. Verification Information From Other Sources

1. Relatives of Institutionalized Beneficiaries
2. Rent Receipts
3. Contributions to Household Budget
4. Sources of Payments for Costs of Institutionalization
5. Property Tax Records

For needy individuals under 21, the QC reviewer must verify that the beneficiary was in a required living arrangement as of the review month whenever it is a function of Medicaid eligibility. This may frequently be done through a review of institutional records. For example, if the State provides Medicaid to all needy individuals under 21 who are in foster care, the reviewer must verify under this element that the beneficiary was in the required living arrangement during the review month.

150 DEPRIVATION - This element must be verified for all AFDC related beneficiaries reviewed.

Categorical relatedness of a child is based upon a determination of deprivation of parental support or care due to death, incapacity, continued absence, or unemployment of the father. When the State plan provides that Medicaid benefits be extended to the parent of an unborn child, the conditions of eligibility are the same as applied to parents of other children. In such cases the reviewer must verify that pregnancy has been established by medical diagnosis.

The reviewer will establish and verify deprivation under the appropriate sub-element listed below.

151 DEATH - The reviewer will verify the death and the relationship of the deceased to the child. A death certificate is the primary verification for death. When a death certificate is not available, other sources of verification will be used.

a. Verification Information Generally Available From The Beneficiary

1. Death Certificate
2. RSDI Record of Lump Sum Death Payment
3. Veterans Administration Death Payment Correspondence
4. Insurance Company Death Settlement Correspondence
5. Veterans Administration Record of Widow's or Survivor's Benefits
6. RSDI Survivor's Benefit Notice

b. Verification Information From Other Sources

1. Bureau of Vital Statistics
2. Newspaper Death Notice
3. Insurance Company Records
4. Social Security Records
5. Funeral Director
6. Veterans Administration
7. Hospital Records
8. Institutional Records
9. Military Service Records
10. Public Assistance Records
11. Case Record and Burial Payment File
12. Lodge, Club, or Fraternal Organization Records
13. Union Life Insurance Records
14. Police Records

152 INCAPACITY - The reviewer will verify the incapacity and the relationship of the incapacitated person to the child(ren). State policy requirements in regard to establishing and verifying incapacity will be followed. Reports from State agency medical review units which certify incapacity will be accepted as verification where these are applicable.

State policy pertaining to incapacity varies widely from State to State. For some States, the only acceptable determination of incapacity is certification by a designated State review unit. In other States, a physician's statement suffices.

Medical statements which specify a time span for the duration of the incapacity may be used for documentation when the review month falls within such a time span. Medical reports which show the incapacity as continuing with no prognosis for improvement are also acceptable verification of incapacity.

a. Verification Information Generally Available From The Beneficiary Or Case Record

1. Disability Certification by State Medical Review Unit
2. Medical Examination Report
3. Receipt of RSDI (Disability) Benefits
4. Receipt of SSI Benefits based on Disability
5. Medical Statement from Doctor, Hospital, or Clinic
6. Visual Observation of the Disability, when Permitted by State Plan

b. Verification Information From Other Sources

1. Medical Records or Disability Examination Report
2. Physician's Records
3. Hospital Records
4. Clinic Records
5. Bureau of Vocational Rehabilitation
6. Veterans Administration
7. Rehabilitation Center Records
8. Office of the Blind or Visually Handicapped Case Record
9. School Records
10. Voluntary Social Service Agencies, i.e., Speech and Hearing Clinics, etc.

11. Sheltered Workshop Records
12. Psychometric Tests
13. Psychological Test Records
14. Psychiatric Records
15. Associations for Handicapped or Disabled, such as Muscular Dystrophy, Multiple Sclerosis, Heart Association, etc.

153 CONTINUED ABSENCE - The reviewer will verify such continued absence and whether or not support payments were made. (The receipt and amount of support payments, however, are evaluated under program area INCOME). Continued absence does not include situations where family ties are intact but the father is away looking for work or working elsewhere. In those situations in which the absent parent's whereabouts are known, contact to obtain evidence of absence from the home of the family is the recommended procedure. The absent parent will generally be able to establish the facts through documents such as rent receipts, driver's license, support payment receipts, etc.

When the absent parent's whereabouts are unknown, the reviewer will verify absence through the best available source of verification. For example, if a Social Security number is available, the reviewer can check State Employment Security Office wage records, Social Security wage records, and records of the Internal Revenue Service for the address shown on past tax returns filed by the absent parent. Through an accumulation of corroborating evidence the absence or presence of the parent can be determined.

a. Verification Information Generally Available From The Beneficiary

1. Divorce Papers
2. Separation Papers
3. Military Service Papers or Induction Notice
4. Annulment Papers

b. Verification Information From Other Sources

1. Contact with Absent Parent
2. Shelter Record of Absent Parent, e.g., Lease, Rent Receipts, etc.
3. Court Records
4. Correctional Institution Records
5. Social Security Clearance (Form SSA-1472)
6. Internal Revenue Service Records
7. Directories

8. Post Office Record of Address
9. Motor Vehicle Registration
10. Driver's License
11. Unemployment Compensation Records
12. Union Records
13. Lodge, Club, or Fraternal Organization Records
14. Law Enforcement Officials
15. Probation Office Records
16. Public Assistance Records
17. Voter Registration Records
18. Community Organizations, Block Clubs, etc.
19. Statements from Reputable Sources in the Community
20. Employment Security Records
21. Agency Support or Location Unit Records
22. Employer's Records
23. Telephone Directory

154 UNEMPLOYED FATHER - The reviewer will verify "unemployment" within the State's definition. Verification of deprivation of parental support due to unemployment is a complex process which includes several determinations. Each of these must be carried out and substantiated. The unemployed father must have been in the labor market prior to application, as defined in the State plan; must be registered with the public employment office; and must not have refused employment without good cause. In accordance with State policies, unemployment may include part-time employment. Actual income from employment, if any, must be verified in the INCOME program area.

The primary sources of information for substantiating these factors are payroll slips, the local State employment service, the Unemployment Compensation office, and if the father was employed, the employer.

a. Verification Information Generally Available From The Beneficiary

1. Unemployment Compensation Payment
2. Current Employment Registration Card
3. Company Lay-off Notice

b. Verification Information From Other Sources

1. Unemployment Compensation Record
2. Bureau of Employment Security Employment Office
3. Employer's Records

4. State Employment Agency Records
5. Training Program Records
6. Union Records

Note: If a deprivation factor does not exist, a child may still be eligible as a needy individual under 21, if the family is low income and the State covers that group.

160 BLINDNESS/DISABILITY DETERMINATION - This element must be verified for all SSI related beneficiaries reviewed whose basis for eligibility is blindness or disability.

Age, blindness, or disability provides the basis for SSI categorical relationship. However, the QC reviewer should not attempt to determine blindness or disability himself. If the medical determination was certified as having been made and limits to the period had been established, that documentation should be used to verify blindness or disability in the review. The reviewer should confirm that program requirements (e.g., time limitations on the period of disability) were applied correctly. However, the reviewer should not attempt to verify any medical factors of eligibility.

If (1) the period covered by the medical determination expired before the review month or (2) blindness or disability have to be determined based on criteria different from those in use by the State when the last determination was made, the beneficiary must be referred to the appropriate State agency for a new medical determination. The QC reviewer should not close a review until this information has been received. In unusual circumstances in which the QC reviewer has reason to suspect a change in blindness or disability status based on observation of the beneficiary within the established time limits, the beneficiary may be referred to the State agency for redetermination. If the medical redetermination is not completed prior to the deadline for case completions, then the reviewer will report the case ineligible-agency error, and be coded as Element 540, Nature 83, Type 60.

a. Verification Information Generally Available From The Beneficiary Or Case Record

1. Disability Certification by State Medical Review Unit
2. Medical Examination Report
3. Beneficiary of RSDI (Disability) Benefits
4. Beneficiary of SSI Benefits Based on Disability

5. Medical Statement from Doctor, Hospital, or Clinic
6. Visual Observation of the Disability when Permitted by State Plan

b. Verification Information From Other Sources

1. Medical Records or Disability Examination Report
2. Physician's Records
3. Hospital Records
4. Clinic Records
5. Bureau of Vocational Rehabilitation
6. Veterans Administration
7. Rehabilitation Center Records
8. Office of Blind or Visually Handicapped Case Record
9. School Records
10. Voluntary Social Service Agencies, i.e., Speech and Hearing Clinics, etc.
11. Sheltered Workshop Records
12. Psychometric Tests
13. Psychological Test Records
14. Psychiatric Records
15. Associations for Handicapped or Disabled, such as Muscular Dystrophy, Multiple Sclerosis, Heart Association, etc.

170 MARITAL STATUS - This element must be completed for all SSI related beneficiaries reviewed whenever potential eligibility for SSI benefits is a factor of Medicaid eligibility. Marital status is important in that (1) the SPA on which benefits are based differs depending on whether computations are for an eligible individual, or an eligible couple, and (2) income and resources from an ineligible spouse may be deemed to the potentially eligible beneficiary under certain circumstances.

The requirements for determining marital status are recorded in the SSI Claims Manual.

a. Verification Information Generally Available From The Beneficiary

1. Marriage License
2. Divorce Papers
3. Separation Papers

b. Verification Information From Other Sources

1. Social Security Administration
2. Local Judicial Records

180 OTHER CATEGORICAL RELATIONSHIP REQUIREMENTS - This element must be verified for all beneficiaries in a State which applies additional basic program requirements as a basis for Medicaid eligibility.

Examples of additional basic program requirements are as follows:

1. Participation in cost sharing is a prerequisite to Medicaid eligibility.

2. More restrictive State criteria are applied to SSI beneficiaries as the basis for Medicaid eligibility.

This element must also be used to verify any factors of eligibility for needy individuals under 21 which are not covered elsewhere on the Worksheets. Optional State coverage of needy individuals is only available to beneficiaries under 21, financially eligible for Medicaid, and in approved classifications.

The nature of the approved classification on which the beneficiary's eligibility is based must be defined and verified in accordance with the State plan for this element. For example, if children in foster care are Medicaid eligible in the State, the QC reviewer must verify that the beneficiary is in fact approved for participation in the foster care program as of the review month.

A State's approved classification could be all needy individuals under 21, in which case this Section would not be completed.

3462 Resources (200)

The review of all elements in this program area is necessary for all beneficiaries reviewed, irrespective of program relationship. The reviewer will verify those resources declared by the beneficiary and also fully evaluate the possibility of such resources when they are not declared. Although the beneficiary may not have any of the resources identified, the reviewer's exploration will extend to the point where the absence of each resource can be supported by the conclusiveness of the reviewer's investigation.

Resources whose value are subject to change require particular consideration. These resources, such as real property, bank deposits, or stocks and bonds, are to be independently

verified by the reviewer except when conclusive documentary verification in the case record has been obtained within a 30-day period prior to the review month.

If the value of each resource element is correct and under the allowable amount, but when summed together results in ineligibility, the error should be coded for the resource element with the highest value unless the reviewer can identify a particular resource element/sub-element disqualifying the beneficiary (e.g., most recent change).

210 REAL PROPERTY (HOME AND OTHER) - This element must be verified for all beneficiaries reviewed.

Where it is known from the beneficiary's statement, case record information, or other sources, that there was ownership of real property as of the review month, the reviewer will verify whether such property meets the State agency's definition of a "home" or "homestead", determine whether its value is within the State's established limitations, and determine whether the beneficiary meets the State agency's definition for occupancy of the property. (Income from property ownership is evaluated under the appropriate elements in INCOME).

Where there has been a negative response to property ownership, the reviewer will pursue the investigation to the point where there is support for the finding of absence of property ownership. The reviewer should, where possible, routinely check for property ownership. Such clearance can usually be made through county court house records.

On a selective basis, the reviewer should investigate public records outside of the beneficiary's county of residence. Criteria for such investigation would include information in the case record or from collateral sources, acknowledgement of ownership of property in other areas, past residence in other areas, and patterns of property ownership in the community in which the beneficiary lives.

The reviewer will determine whether the beneficiary owned real property as of the review month, other than that regarded as a home. Where such ownership exists, the reviewer will determine in accordance with State policy, its value as a resource to the beneficiary. If the State plan provides for retention of non-home real property because of its income-producing value, this factor should be considered under this element. The address of the beneficiary during the review month provides another lead to possible ownership of real property.

a. Verification Information Generally Available From The Beneficiary

1. Deed
2. Sales Agreement
3. Mortgage
4. Estate Data
5. Articles of Agreement
6. Real Estate Tax Receipts
7. School Tax Receipts
8. Income Tax Return

b. Verification Information From Other Sources

1. Court House Records
2. Tax Records
3. Real Estate Tax Transfer
4. Title Search
5. Utility Company Records
6. Charge Account or Charge Account Application Records
7. Municipal Building Inspection Compliance Records
8. Municipal Fire Code Records

220 LIQUID ASSETS - This element must be verified for all beneficiaries reviewed.

The value of liquid assets owned by the beneficiary is to be verified by the reviewer in accordance with State policy. Such resources include:

221 Cash-On-Hand
222 Bank Deposits
223 Stocks, Bonds, or Investments
224 Other

Where ownership of such resources exists, the reviewer will establish whether the value of such property was within the State's established limits for its retention as of the review month.

The reviewer will verify the amount of money the beneficiary has on deposit as of the review month in banking institutions when such deposits are identified. This will include the various kinds of bank accounts, e.g., savings, checking, etc.

When the beneficiary denies ownership of any bank deposits, the reviewer should selectively use one or more verifications of nearby neighborhood banks to establish whether the beneficiary

has an account at these institutions, or has an account in addition to one declared. The reviewer may inquire further as to where the beneficiary cashes his check, or what banks, institutions, or sources of financing were used for past transactions, as a means to obtain leads to sources of bank deposits.

a. Verification Information Generally Available From The Beneficiary

1. Bank Books
2. Stock Certificates
3. Bond Certificates
4. Mortgages
5. Notes
6. Securities
7. Credit Union Statements
8. Savings and Loan Statements
9. Bank Statements

b. Verification Information From Other Sources

1. Bank Records
2. Stock Brokers
3. Credit Union Records
4. Judgment and Lien Records
5. Savings and Loan Records
6. Credit Applications
7. Charge Account Applications

230 LIFE INSURANCE - This element must be verified for all beneficiaries reviewed.

When the case record shows ownership of life insurance, the reviewer will verify the pertinent information as of the review month through examination of the policy(ies), records in the possession of the beneficiary, or other documentary sources such as a statement from the issuing company.

When the case record does not show ownership of insurance and the beneficiary denies such ownership, the reviewer will continue further exploration which may include inquiry to local insurance agencies or brokers or employer to establish whether there was ownership of life insurance. To make such exploration as meaningful as possible, the reviewer should carefully evaluate which insurance companies might be a potential carrier for the beneficiary, e.g., by inquiring and checking sources of both existing and non-current policies for automobile, home, personal property, and also policies held by other family members. These inquiries may furnish leads as to which brokers or companies to contact.

Where ownership exists, the reviewer will evaluate the policy(ies) to determine whether the value conforms to the State's established limits for insurance, and that any other State requirements with respect to life insurance have been met.

a. Verification Information Generally Available From The Beneficiary

1. Insurance Policies
2. Burial Reserve Agreements
3. Burial Agreement with Funeral Director

b. Verification Information From Other Sources

1. Clearance with Insurance Company
2. Insurance Payment Book
3. Clearance with Insurance Agent
4. Employer's Insurance Records
5. Lodge, Club or Fraternal Organization Records
6. Funeral Director
7. Relative and Friends Holding Policies for Beneficiary
8. Union Records
9. Veterans Administration Records
10. Credit Applications or Charge Account Applications

240 MEDICAL INSURANCE - This element must be verified for all beneficiaries reviewed.

Depending on the State plan, medical insurance may be an element of eligibility determination. When medical insurance is considered a resource, it should be verified for this element. However, development of possible income deductions for medical insurance premiums should be developed under Element 420.

When medical insurance is an element of liability determination, either through income deductions or through other conditions, the QC reviewer should verify its existence through examination of documents in the beneficiary's possession and through contact with collateral sources. In cases where medical insurance is not an element of liability determination in the State plan, the QC reviewer should endeavor to obtain all possible information regarding third party payment sources from the beneficiary. However, contacts with collateral sources, such as insurance brokers or insurance companies, should not be undertaken until paid claims for services received during the review month are collected for the TPL QC review. This delay in contacting collateral sources (for cases in which medical insurance is not

an element of eligibility) allows the TPL QC reviewer to question insurance companies or other collateral sources, e.g., employers, on insurance coverage information specifically related to the services received in the review month.

In the case that the availability of medical insurance is identified during the case record review or field investigation, the following information should be obtained for third party liability review:

1. The correct insurance carrier name and claims office address;

2. The name of the insured; both group policy name, where applicable, and individual policyholder name;

3. The policy number; group number, where applicable, and individual identification number;

4. The effective date of the policy; including whether the policy was in effect for all or a portion of the review month;

5. The names and relationship of the other case members covered by the policy of the insured.

For cases in which medical insurance is available in the form of a Government program; e.g., Medicare, identifying information comparable to the items noted above should be obtained.

For cases in which the existence of medical insurance must be verified through collateral contacts to meet conditions of eligibility, additional medical insurance information should be collected to facilitate the conduct of third party liability review. The specific information items essential to TPL review are given in Chapter 3500. To summarize, Chapter 3500 requires the QC reviewer to obtain information about the specific medical services covered, dollar limitations, deductibles, coinsurance and co-payment requirements of the health insurance policy under which a beneficiary is covered. Before contacting employers, insurance companies or other collateral sources, the reviewer should become familiar with the items in Subchap 3550 and, whenever possible, obtain that information from collateral sources. This will prevent unnecessary duplication of effort in the eligibility and TPL review.

The availability of the types of medical insurance listed on the following page should be investigated, where appropriate, for each member of a case.

1. Private health insurance held by a case member. These policies may be individual or group policies available through an employer, union, fraternal organization or other source, and may include hospital, medical and surgical policies, and/or supplemental or major medical policies.

2. Membership in a Health Maintenance Organization (HMO).

3. Private health insurance available through an absent parent who is legally responsible for medical support.

4. Medical coverage available through Government programs other than Medicaid. These programs include Medicare (Part A and Part B), the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) and Veterans Benefits.

5. Maternity confinement expenses, where applicable.

The reviewer should reference the descriptions of population groups that may be covered under the health insurance and program types noted above. These descriptions are given in Section 3520. That Section also provides general descriptions of the services often covered under the various policies or programs.

If a beneficiary verifies the existence of medical insurance by presenting the carrier's policy or a statement of coverage, the QC reviewer should obtain all pertinent facts regarding the coverages and limitations of the policy, HMO membership, etc.

The QC reviewer should be aware that medical support by an absent parent can include court ordered insurance coverage and/or payment of medical expenses. Both insurance through an absent parent and direct payment of medical expenses are to be reviewed and documented under Element 240. Review of medical support will generally require the reviewer to coordinate with the State Office of Child Support Enforcement. However, the cooperative agreement between that Office and the Title XIX agency will specify which unit will maintain the verification information.

If, during the field investigation, potential third party liability through medical insurance is identified, the QC reviewer must secure an authorization from the beneficiary for the release of information from insurance companies and other collateral sources. While Medicaid providers are required to open their files to State review, private insurance companies and other collateral sources are under no obligation to release information pertaining to Medicaid beneficiaries and will, in general, require a signed statement from the beneficiary before they will do so. Typically, a State will have developed an "authorization of medical information" or similar form for use in third party recovery activities. Where possible, existing State release forms should be utilized.

a. Verification Information Generally Available From The Beneficiary

1. Insurance Card
2. Medicare or CHAMPUS Card
3. Pay Stub Indicating Insurance Deductions
4. HMO Membership Card or Contract
5. Court Order for Health Insurance Coverage by an Absent Parent
6. Insurance Policy
7. Cancelled Checks for Medical Insurance

b. Verification Information From Other Sources

1. Statement of Coverage from the Insurance Carrier or HMO
2. Employer's Insurance Records
3. Veteran's Administration Records
4. CHAMPUS Agency Files and Records
5. Military Records of Active Duty Armed Services Personnel
6. Court Records on Medical Support Obligations of an Absent Parent, State Office of Child Support Enforcement
7. Title IV-D Agency Records of Absent Parent Obligations for Medical Support
8. State Data Exchange Tapes for SSI Recipients Eligible for Medicare
9. State Records on Part B Medicare Buy-ins

In recording the availability of medical insurance on the Worksheets, the QC reviewer should enter whether the case record indicated insurance, whether the beneficiary interview was the source of the coverage information, or whether collateral contacts supplied the first indication of medical insurance coverage.

If one type of health insurance or one medical insurance policy is indicated in the case record but has been replaced by another or is not in effect during the review month, these facts should also be noted on the Worksheets. As well, the reviewer should always indicate negative findings; i.e., no medical insurance available.

The review of both elements incorporated in program area 240 is applicable to each beneficiary reviewed regardless of program relationship.

The reviewer will determine whether each beneficiary has received medical services during the review month and whether these services were associated with an accident or casualty situation for which a third party may be liable.

Elements 241 and 242 cannot result in an eligibility error. The purpose of these two elements is provision of information for TPL review.

241 MEDICAL SERVICES DURING REVIEW MONTH - During the beneficiary interview the QC reviewer should determine whether medical services were received by anyone in the Medical Assistance Group during the review month. The reviewer should obtain information on all possible types of medical services, including those not covered by Medicaid. A list of general service types to be included is given in Subchap 3580.

For each case member, the following information regarding medical services received in the review month should be obtained:

1. The illness or injury for which the service was rendered.

2. The services received, e.g., physician office visit including, for example, physical examination, chest x-ray, urinalysis and blood tests, names or types of prescription drugs, appliances prescribed, etc. Each separate element of medical service should be listed.

3. The provider of each medical service, e.g., the name of the hospital, operating physician, radiologist, other specialist, pharmacy, etc.

4. The payment source and indication to the provider of such for each service, e.g., Medicaid card, Medicare card, etc.

Worksheets shown in Subchap 3480, are provided to the QC reviewer for recording the information noted above.

Verification of medical services through collateral contacts such as the provider is not required.

242 ACCIDENT RELATED THIRD PARTY LIABILITY - During the beneficiary interview, the QC reviewer should determine whether any medical services received by the beneficiary during the review month were the result of injuries or illnesses resulting from an accident. The cause and circumstances of the accident should be thoroughly explored with the beneficiary to allow the QC reviewer to determine whether there is sufficient indication that a third party may be liable and whether more extensive investigation is warranted.

Subchap 3523 describes the types of third party liability that may result when accidents occur under various circumstances. The areas covered include automobile accidents, accidents or injuries in the beneficiary's workplace, and accidents occurring in other than the beneficiary's home or workplace, e.g., a restaurant, department store, a neighbor's house.

If a relevant accident is identified the QC reviewer should obtain the following information:

1. Circumstances of accident or illness;
2. Date of accident or illness;
3. The case members involved in the accident;
4. Place of accident;
5. The individual (name and address) the beneficiary believes to be responsible and whether any legal action has been taken;
6. Name and address of any attorney representing the beneficiary;
7. Employment related accidents -
   a. Employer name and address;
   b. Records of accident report;
   c. Beneficiary's employee identification number;
   d. The employer's Workmen's Compensation number;
   e. Whether the employer's (or carrier's) liability has been accepted or denied;
   f. Whether benefits have been received or are expected from the Workmen's Compensation carrier;
8. Automobile Accidents -
   a. Role of beneficiary, e.g., driver, passenger, pedestrian;
   b. Number of cars in accident;

c. Availability of automobile insurance (no-fault or other) to any passengers or drivers involved in the accident and identification of insurance companies (name and address);
d. Whether any individual has been charged with traffic violations as a result of the accident, if so, obtain name and address;
e. Whether a police report was made;
f. Whether any claims have been filed with an insurance carrier as a result of the accident (identify carrier and claims' numbers);
g. Whether any benefits have been received from the insurance carrier;
h. Whether relatives residing with the beneficiary have insurance coverage and, if so, the names of the relatives and insurance company and the company's address;

9. Other accidents that may involve third party liability for medical expenses -
a. The insurance company involved (name and address);
b. Accident reports;
c. Whether written documentation acknowledging responsibility of a third party is accepted or denied.

Verification instructions for casualty related third party liability through collateral contacts are given in Section 3553. Verification procedures through collateral sources should not be initiated until paid claims for accident related services during the review month are available to the reviewer.

250 OTHER PERSONAL PROPERTY (Include motor vehicle and other resources) - This element must be verified for all beneficiaries reviewed.

Any other personal property of the beneficiary must be verified under this element. For example, if the beneficiary received an inheritance during the review month, it should be verified here. Also, documented for this element should be resources deemed from parent or spouse to SSI related beneficiaries.

Some State plans require identification of ownership and evaluation of the value of vehicles. When this is the case, the reviewer will verify ownership of a motor vehicle(s) as of the review month. The primary verification for ownership is clearance with the State agency responsible for the registration of motor vehicles. This agency can establish whether the beneficiary owned a vehicle. In some States, the agency can also furnish evaluative

data on the vehicle. Information available usually includes the purchase price, encumbrances against the vehicle, and the name of the organization financing the purchase. This information will aid the reviewer in evaluating the effect of car ownership on eligibility. The "blue book" of car valuations is an additional source to establish the value of motor vehicles. Other sources include car dealers who can provide an approximate valuation based on make, year, and model of the vehicle. The State motor vehicle registration agency can also be used to establish non-ownership of a vehicle.

a. Verification Information Generally Available From The Beneficiary

1. Car Title and Registration
2. Auto Financing Data

b. Verification Information From Other Sources

1. Motor Vehicle Registration
2. Credit Accounts
3. Credit Applications
4. Charge Account Applications

260 DISPOSAL OF PROPERTY - This element must be verified for all beneficiaries reviewed.

The reviewer will determine whether the beneficiary has disposed of or transferred any property prior to certification of Medicaid eligibility, and if so, whether such disposal of property was within the limits prescribed by the State requirements.

The reviewer, in accordance with State provisions, will consider the type of property (real or personal), its valuation, consideration received for the transfer, and time period of the transfer. In situations where the beneficiary acknowledges that property was transferred, the beneficiary and the transferee will generally have some type of documentation to provide the necessary verification. When the beneficiary advises that he has not transferred property within the time limits of the State regulations, the reviewer will evaluate the beneficiary's circumstances, past and present, and check court transfer records to reach a basis for supporting a decision on disposal of property.

a. Verification Information Generally Available From The Beneficiary

1. Transfer Papers
2. Deed
3. Mortgage
4. Articles of Agreement

5. Sales Agreement
6. Real or Personal Property Tax Statements
7. State and Federal Income Tax Statements
8. Cancelled Checks or Receipts

b. Verification Information From Other Sources

1. Court Records
2. Real Estate Tax Stamps
3. Tax Records
4. Attorney's Records
5. Real Estate Agent or Broker
6. Stockbroker
7. Utility Company Records
8. Motor Vehicle Registration

3462 Income (300)

The review of all elements in this program area is applicable for each beneficiary reviewed irrespective of program relationship.

The reviewer will determine, with respect to each element, whether or not there is income and whether there has been a correct determination of the amount of income, for the State's period for computation of income which includes the review month.

The reviewer will verify income declared or shown in the case record and also evaluate fully the possibility of additional income as well as income when none is declared or shown in the case record.

Sources of income include earned income, RSDI benefits, other government program benefits, pensions or other benefits, support payments, income in-kind or deemed, and other income such as income from rental property, farm produce, roomers - boarders, child care, etc.

During the QC investigation, it may be discovered that the beneficiary appears to be eligible for benefits of which he and the local agency are unaware, e.g., Social Security benefits, lapsed insurance, support from absent parents or private pension benefits. These potential benefits are not relevant to the determination of eligiblity as of the review month because they are not actually being received during that month. Development of the potential resource is not a function of QC. Therefore, a notification of such benefits will be made to the local agency through the appropriate State agency staff.

310 EARNED INCOME - This element must be verified for all beneficiaries reviewed.

The reviewer will determine whether or not a beneficiary was working during the review month and verify the amount of earnings, if any.

Where State policy has established a procedure for averaging or estimating irregular earnings, the reviewer is to accept the local agency's estimate of earnings except where (a) there have been unreported changes in the past which could affect the beneficiary's eligiblity status, e.g., part-time to full-time job, loss of job, changes of job, etc., (b) the local agency has not acted on changes reported by the beneficiary, (c) the beneficiary withheld or gave incorrect information to the local agency when the estimate was made, (d) the time period for which the estimate was made has expired, or (e) the local agency obtained incorrect information or used accurate information incorrectly.

When QC cannot accept the average used by the local agency for any of the above reasons, the reviewer will utilize the time period specified in State policy for averaging and recompute the appropriate average amount of earnings to be applied to needs in order to determine eligibility for medical assistance during the review month.

The rationale for this procedure is that if the Medicaid eligibility worker secured the proper information and applied the State income averaging policy correctly, any difference between the estimated income and actual would not be considered an error for the purposes of Medicaid QC.

The primary verification for declared earnings is the employee's pay record of wages received from his employer (pay stubs, etc.). When the beneficiary does not have this verification available, it can usually be obtained from the employer's records.

When the beneficiary states that he had no earnings, verification becomes more difficult. The reviewer must go beyond the beneficiary's statement to reach a basis for a decision in regard to earnings. Such an investigation should include exploration with the beneficiary as to past employment history, types of work, former employers, current attempts to find work, and registration with the Employment Security Office. Information may also be obtained from collateral contacts with other individuals, while verifying other elements of eligibility, which may show that the beneficiary is frequently absent from the home during regular working hours. This information may indicate that the beneficiary was employed full or part-time.

All beneficiaries identified in the Medicaid QC sample of cases should be cleared routinely through the wage record files of either the State Employment Security Office (contingent upon the availability of such records from these SES offices), or the Social Security Administration (SSA) in Baltimore which maintains those individual wage records for States which do not maintain their own. Although the information obtained from these wage record clearances is not always current to the review month, it can provide leads for further investigation. When the employment clearance records do indicate past employment for the beneficiary, the reviewer will check with the beneficiary and with the respective employer to verify the beneficiary's employment situation during the review month.

a. Verification Information Generally Available From The Beneficiary

1. Pay Stubs
2. Pay Envelope
3. Employee's W-2 Form
4. Wage Tax Receipts
5. Income Tax Return - State and/or Federal
6. Self-Employment Bookkeeping Records of Beneficiary
7. Sales and Expenditure Records

b. Verification Information From Other Sources

1. Employer's Wage Records
2. State Form for Clearance of Earnings from Employment
3. Statement from Beneficiary's Employer
4. Employment Security Office
5. Occupation Tax Agency
6. Local Wage Tax Agency
7. State Income Tax Bureau

320 RSDI BENEFITS (SOCIAL SECURITY) - This element must be verified for all beneficiaries reviewed.

The reviewer will determine whether the beneficiary was receiving RSDI benefits during the review month and verify the amount of such benefits.

The primary verification for RSDI benefits is the Beneficiary Data Exchange (BENDEX) system, i.e., the automated communication system between State welfare agencies and SSA in Baltimore regarding social security benefits. SSA Form 1610 (Request for Information by State Public Assistance Agency) should be used when BENDEX information is not available; or, when special circumstances warrant, the reveiwer may check directly with the

SSA district office to obtain RSDI benefit information. These offices have microfilm records of payments to beneficiaries, and will generally furnish the benefit data by a printout. The clearance may be made by social security number and/or name.

A routine clearance for RSDI benefits should be made for all instances when an AFDC categorically related child is deprived of parental support because of death or incapacity.

a. Verification Information Generally Available From The Beneficiary

1. RSDI Benefit Payment Check
2. RSDI Award Letter
3. Correspondence from SSA on Benefits

b. Verification Information From Other Sources

1. Beneficiary Data Exchange (BENDEX) System
2. Social Security (Form SSA-1610)
3. Social Security District Office Files

330 BENEFITS FROM OTHER GOVERNMENT PROGRAMS - This element must be verified for all beneficiaries reviewed.

The reviewer must verify whether or not the beneficiary received cash benefits from any other government programs during the review month. Circumstances of the beneficiary may provide leads to certain types of government program benefits. Examples of other government program benefits are represented by the following sub-elements:

331 Veterans Benefits
332 Unemployment Compensation
333 Workmen's Compensation
334 SSI
335 Civil Service Retirement
336 Other Government Program Benefits

a. Verification Information Generally Available From The Beneficiary

1. Unemployment Compensation Award Letter
2. Pension Award Notice
3. Veterans Administration Award Letter
4. Railroad Retirement Award Letter

b. Verification Information From Other Sources

1. Bureau of Employment Security - Unemployment Compensation Section

2. Workmen's Compensation Records
3. Veterans Administration
4. Railroad Retirement Board
5. Social Security Administration - Black Lung Program and Supplemental Security Income Program

340 PENSIONS OR OTHER BENEFITS - This element must be verified for all beneficiaries reviewed.

The reviewer will verify receipt of pensions and/or benefits (other than RSDI) and determine the correct amount of income for inclusion in the budget. This element refers to income from:

1. Private Annuities
2. Company Pension
3. Union Retirement Benefits

When it is known from the beneficiary's statement, case record information, or other sources that the beneficiary receives such pension or benefit income, the reviewer will verify receipt of income and establish the amount received.

When the beneficiary states that he does not receive a benefit, the reviewer should evaluate this statement in terms of the beneficiary's background, past work history, and present circumstances. For example, review of the beneficiary's employment history may indicate possible eligibility for a company retirement pension, past union membership could indicate possible benefits from that source, etc. The reviewer must establish a basis for a decision of non-receipt of benefits more substantial than the beneficiary's denial of the resource. The Worksheet recording should clearly state the basis for the decision.

a. Verification Information Generally Available From The Beneficiary

1. Correspondence on Benefits
2. Income Tax Record - State or Federal

b. Verification Information From Other Sources

1. Employer's Records
2. Union Records
3. Lawyer's Records
4. Insurance Company Records
5. Lodge, Club, or Fraternal Organization Records
6. Personal or Income Tax Records
7. United Mine Workers Union (Black Lung Benefits)

350 SUPPORT PAYMENTS - This element must be verified for all beneficiaries reviewed.

The reviewer will determine whether support payments from parents, relatives, or other persons were, in fact, being made, verify the amount of the payments, and determine if the payments were made on a regular basis. This element refers to:

1. Court-ordered Support Payments
2. Any Voluntary Support Payments
3. Divorce/Separation Agreement for Support

To the extent possible, the reviewer will utilize the resource unit within the agency that deals with support payments.

The reviewer must bear in mind the degrees of liability for support under the State plan. The primary source for verification of support payments is contact with the person making the payment. In situations where legal liability has not been established nor paternity acknowledged, contact of separated parents or relatives by the QC reviewer for the purpose of verifying support contributions, subject to State policy, should normally be made only where there is some indication of a support contribution. In all situations, prudence and tact should be exercised in the contact process in order not to violate the confidentiality of the individuals involved.

When support payments are made through a third party, such as a court or probation office, verification can be made through that agency. The reviewer must be alert to the effect of timing and amount of payment in relation to the review month.

For AFDC categorically related beneficiaries, when the beneficiary advises that the family does not receive support payments and the whereabouts of the person liable for support is known, the reviewer should verify non-receipt through contact with the person liable for such payments. In cases where the absent parent's address is not known, the reviewer must record the leads pursued as the basis for his decision that support payments are not received.

a. Verification Information Generally Available From The Beneficiary

1. Divorce or Separation Papers
2. Court Order
3. Contribution Check
4. Support Agreements
5. Correspondence on Support Payments

b. Verification Information From Other Sources

1. Court Record
2. Probation Office Record
3. Statement of Person Making Contribution
4. Lawyer's Records
5. Cancelled Checks of Person Making Contribution
6. Receipts for Contribution
7. Income Tax Returns
8. Employer Records of Attached Wages

360 INCOME, IN-KIND OR DEEMED - This element must be verified for all groups of beneficiaries reviewed subject to State in-kind or deemed income requirements.

Any income in-kind or deemed to which a money value is given must be verified under this element. For example, for AFDC related beneficiaries the value of shelter provided by another person on a recurring basis must be determined. Also, documented for this element should be the amount of income deemed from parents or spouse to an SSI related beneficiary.

370 OTHER INCOME - This element must be completed for all beneficiaries reviewed who have income not already recorded on the worksheets, if any.

The reviewer will verify whether any income not previously considered under the above INCOME items is actually received and, if so, determine the correct amount for inclusion in the computations. This element refers to other cash income such as income received on a recurring basis from rental property, farm produce, boarders-lodgers, child care, etc.

Verification necessary to reach a definitive conclusion in this element will depend upon the particular type of income being evaluated. As "other income" covers all income not enumerated under the individual elements, the reviewer will evaluate the beneficiary's situation to ascertain the possibility of such additional sources of income.

a. Verification Income Generally Available From The Beneficiary

1. Rental Agreement or Lease
2. Receipts for Service Provided

b. Verification Information From Other Sources

1. Rent Receipts of Tenant, Roomer, or Boarder

2. Statement of Person Providing Financial Aid
3. Receipts, Agreements, Leases

3463 Computations of Financial Eligibility (400)

Elements in this program area must be completed for all beneficiaries irrespective of program relationship. The QC reviewer must verify the accuracy of the computations on which Federal financial participation and beneficiary financial eligibility for Medicaid is based.

This section may also be used to document computations of potential cash benefits eligibility, when that is the basis for Medicaid eligibility. Once the AFDC Related Need Requirements (Elements 510-520) or the SSI Standard Payment Amount (Elements 140 and 170) have been established, and income amounts have been verified, program area 400 may be utilized to determine potential cash assistance eligibility. When these computations are required, the State should utilize its own AFDC budget form, or if available, its own SSI budget form. For States without their own SSI budget form, an example of an SSI eligibility worksheet is provided in Subchap 3480.

410 COMPUTATION OF INCOME - This element must be reviewed and verified for all beneficiaries who have income. Specifically, in this element the reviewer must compute gross income from the income verified under the 300 INCOME elements which include:

1. Earned income amount (e.g., computing monthly gross earned income from weekly amount);
2. RSDI benefits;
3. Other government program benefits;
4. Pensions or other benefits;
5. Support payments;
6. Income in-kind or deemed;
7. Any other income such as income from rental property, farm produce, roomers-boarders, child care, etc.

420 DEDUCTIONS TO INCOME - This element must be reviewed and verified for all beneficiaries who have income computed in Element 410.

Net countable income is derived by applying State designated allowable deductions to the total income computed under Element 410. The QC reviewer must verify that the proper deductions were utilized and that the correct amount of deductions were computed.

If computing potential SSI or AFDC cash eligibility, there are a number of exclusions which must be applied to income in computing potential benefits. These exclusions must be verified for this element. The SSI related exclusions are discussed in the SSI Claims Manual.

Earned income deductions to be applied in computing potential cash eligibility are as follows:

Major SSI related earned income deductions:

- Irregular earnings exclusion ($30 per quarter)
- Income of student
- Remainder of $60 quarterly general exclusion
- $195 + 1/2 remaining earnings quarterly
- Blind work expenses
- Self support plan exclusions

Major AFDC related earned income deductions:

- Mandatory deductions
- Work related expenses
- Child care expenses

There are additional income deductions in both the AFDC and SSI programs which must be applied to any available income in computing potential benefits. These deductions must also be verified for this element, and include:

AFDC related deductions:

- Relocation expenses
- Student loans
- Income set aside for future needs

SSI related deductions:

- Tax refunds
- Assistance based on need
- Scholarships
- 1/3 child support
- $60 quarterly general exclusion
- Irregular income exclusion ($60 per quarter)

For the AFDC program, and for optional SSI State supplements (even if Federally administered), the State may designate additional exclusions and adjustments to be applied to income for computational purposes. Information concerning any additional State designated deductions should also be recorded for this element.

a. Verification Information Generally Available From The Beneficiary

1. Pay Stubs - Taxes and Mandatory Expenses
2. Receipts for Work-Related Expenses
3. Receipts for Child Care Expenses, etc.

b. Verification Information From Other Sources

1. Employer's Payroll Records
2. Tax Statements
3. Contact with Person Providing Services, i.e., Child Care, Transportation, etc.

430 ARITHMETIC COMPUTATION - This element must be verified for all beneficiaries reviewed where financial eligibility for Medicaid must be computed.

Once income, need requirements if applicable (AFDC related), SPA if applicable (SSI related), and deductions are established, the arithmetic computations to arrive at a decision concerning Medicaid financial eligibility is made by comparing net countable income with the State's financial eligibility standards.

This item also refers to the mechanics of addition, subtraction, and percentage adjustments of the individual budgetary items as given. It does not for instance, refer to the correctness of the individual budget items which are recorded under the separate elements of AFDC categorically related beneficiaries (510-520). It does refer, however, to an error that is solely a transcription error, e.g., transferring dollar amount figures from one form to another. If the addition of the need allowances or establishment of SPA, the subtraction of income, and the application of percentage adjustments are mathematically correct, then the arithmetical computation of payment for this element is correct even though one of several budget or income items may be in error or questionable.

440 BENEFICIARY LIABILITY DETERMINATION - This element must be reviewed and verified for all beneficiaries for whom Medicaid eligibility is based on the case members liability to apply excess income and/or resources to an equal amount of incurred medical expenses, e.g, (1) the medically needy (2) the institutionalized categorically needy and (3) the individuals in 209(b) States who may spend-down to become categorically needy.

The QC reviewer must verify that the agency correctly computed medical expenses utilized to offset excess income and that the case had met its liability as computed prior to being certified by the agency. Instructions for use of the case liability worksheet are discussed in Subchap 3480. The liability worksheet in Subchap 3480 or an appropriate State form must be utilized by the QC reviewer to document his computations.

The QC reviewer must also determine which of the incurred medical expenses were paid by a third party(ies) and not a beneficiary. Medical expenses paid by a third party(ies) must not be used to offset excess income and not be counted as incurred by beneficiary when determining eligibility and/or liability status.

3464 Other Medicaid Coverage Requirements (500)

This program includes elements of eligibility which apply only to certain groups of Medicaid beneficiaries, and must be completed on an infrequent basis.

510 AFDC RELATED BUDGETARY ALLOWANCES - This element must be reviewed and verified for all beneficiaries for whom Medicaid eligibility is based on potential AFDC cash eligibility.

Whereas the computation of potential SSI eligibility is based on a Standard Payment Amount adjusted only for living arrangement and marital status, the computation of potential AFDC cash eligibility in many States begins with the establishment of financial need requirements. This program area deals with the verification of the various components of financial need for AFDC categorically related beneficiaries.

1. Budget Allowance Items

   If the State computes need on an "as paid" cost basis, then this element must be completed by the reviewer.

   Included for this element are:

   1. Food
   2. Clothing
   3. Shelter
   4. Fuel and/or Utilities
   5. Other Basic Allowances (e.g., allowance for home repairs)

If the household expenses utilized as a basis for computation of need on a cost basis are shared between members of the Medicaid assistance group and others, the QC reviewer must also verify that the apportionment of expenses by the agency was correct.

a. Verification Information Generally Available From The Beneficiary

1. Rent Receipts
2. Lease
3. Tax Statements
4. Utility Bills
5. Water and Sewage Bills
6. Refuse Disposal Receipt
7. Home Insurance Policies
8. Mortgage Payment Receipts
9. Sales Agreement or Purchase Contract
10. Home Repair Bills

b. Verification Information From Other Sources

1. Contract with Landlord
2. Contract with Property Grantor
3. Real Estate Agent
4. Utility Companies
5. Tax Assessor
6. Property Records and Title Search
7. Court House Property Records
8. Municipal Taxing Authority
9. Records of Financial Institution Handling Property Transfer
10. Records of Public Housing Authority

2. Consolidated Standard

If the State utilizes a flat grant approach in determining the amount of need to be utilized in computing potential AFDC benefits rather than computing budgetary allowances, the QC reviewer should verify that the proper flat grant amount under the State plan was utilized for the case.

Irrespective of the basis for determining basic AFDC budgetary needs, the QC reviewer must

also determine the proper persons to be included in the beneficiary's budget for purposes of computing potential AFDC benefits in accordance with State policy. He will also verify the identity of the beneficiary.

a. Verification Information Generally Available From The Beneficiary

1. Birth Certificate
2. Marriage License
3. Driver's License
4. Baptismal Certificate
5. Voting Registration Record
6. Credit or Charge Account Cards
7. Military Service Papers
8. Union Membership Card
9. Naturalization Papers
10. Alien Registration Card
11. Passport

b. Verification Information From Other Sources

1. State Bureau of Vital Statistics
2. School Records
3. Church Records
4. Employer's Records
5. Labor Union Records
6. Hospital or Physician's Records
7. Additional Verification - listed earlier under AGE

520 AFDC SPECIAL NEEDS - This element must be reviewed and verified for all AFDC related beneficiaries for whom Medicaid eligibility is based on potential cash eligibility in States allowing special needs as part of the computation. This element will generally not be completed in States utilizing a flat grant approach.

The reviewer will identify the need for and determine the correct amount of an allowance for special circumstances needs, in accordance with State provisions. This element may include the following sub-elements:

521 Child Care
522 Transportation
523 Work Related Expenses
524 Personal Care and Other (e.g., a housekeeping service, laundry)
525 Other Special Needs

The reviewer will identify, substantiate, and make allowances for such needs in conformity with State policy.

a. Verification Information Generally Available From The Beneficiary

1. Doctor's Statement of Special Diet Need
2. Pregnancy Statement from Physician
3. Eviction or Relocation Notice
4. Doctor or Druggist's Statement of Need for Allowance
5. Legal Fee Statement
6. Employment Search Cost Statement
7. Car Payment Record
8. Institutional Statement of Special Needs
9. Transportation Cost Receipts
10. Receipts for Compensable Supplies or Services
11. Union Dues Receipt
12. Telephone Bill Receipts
13. Newspaper Payment Receipts
14. Child Care Cost Receipts

b. Verification Information From Other Sources

1. Statement of Vendor Supplying Goods or Services
2. Doctor's Statement of Need for Allowance
3. Records of Hospital or Clinic
4. Statement of Institution or Agency Requesting or Supplying Services
5. Employment Search Costs - Bureau of Employment Security
6. Prospective Employer's Statement on Cost Necessary to Consider or Accept Client for Employment

530 GRANDFATHERED COVERAGE PROVISIONS - "Grandfathered" provisions apply to beneficiaries for whom Medicaid eligibility is being based on their status as of December, 1973, or August, 1972. This section should be completed to summarize findings when agency or QC reviewer decisions are based on these requirements.

Medicaid eligibility coverage requirements which include grandfathered provision include the following:

1. Recipients of Title II in August, 1972 who would be eligible for cash assistance except for the 20% Title II increase;

2. Beneficiaries eligible for Medicaid in December, 1973 as essential spouses of cash assistance recipients;

3. Beneficiaries eligible for Medicaid in December, 1973, who would have been eligible for cash assistance except for institutionalization;

4. Beneficiaries who were blind or disabled in December, 1973 and meet Medicaid eligiblity financial requirements;

5. Beneficiaries who received SSI/SSP cash benefits who became ineligible for Title XVI cash assistance due solely to RSDI cost-of-living increases received after April, 1977.

The instances in which Element 530 must be completed are specified for the appropriate coverage requirements in Subchap 3470.

540 OTHER STATE MEDICAID COVERAGE CRITERIA - Complete if the beneficiary being reviewed is in an approved Medicaid coverage requirement not listed in Subchap 3470, or if other possible elements of eligibility not included on the worksheets apply to the review. Use this element to record an eligibility error when there is no evidence in agency records (case records) that an appropriate Medicaid eligibility determination had been made by the responsible agency for a beneficiary prior to the review month. These cases will be coded as ineligible.

3470 VERIFICATION GUIDE

The eligibility elements to be verified vary depending upon Medicaid eligibility coverage requirements. The Verification Guide, used during eligibility review and identification of potential third party liability, indicates to the QC reviewer which elements on the worksheets must be verified for each Medicaid coverage group. Prior to commencing reviews, the QC reviewer should have become familiar with the State plan and checked the appropriate columns in the Verification Guide to identify the coverage requirements that apply. This Guide should be followed carefully to insure proper documentation of all eligibility requirements appropriate for the individual beneficiary.

For a specific eligibility coverage requirement under review every applicable element as indicated in the Verification Guide must be reviewed and verified. This applies even if an element is determined to be in error prior to the completion of all elements to be

reviewed. If other errors are found, they will also be reported on the Review Schedule. The Review Schedule provides for reporting the total number of errors identified during the review and allows description of up to five errors. All errors are identified and reported so that subsequent corrective action can be based on complete information about errors which existed during the review month.

Coverage Code (Review Schedule Items J and P)	In State Plan (Check ✓)	Medicaid Eligibility Coverage Requirement	Verification Instructions
01		Individuals who receive SSI basic payments where the State or SSA determines Medicaid eligibility using SSI criteria.	SSI-QA Sample Cases 1. Complete element 160 to verify that SSI beneficiary had been certified as Medicaid eligible by the State. 2. Complete element 240 to obtain potential third party liability and review month services. For State Independent Sample of SSI Cases 1. Verify that the recipient received an SSI basic payment (and supplement if provided) during the review month and record amount under element 330. 2. Complete elements 110, 120, 130, and 160 to verify SSI categorical relationship. 3. Complete elements 140, 170, 210-260, 310-370, and 410-430 to verify financial eligibility for Medicaid based on Title XVI financial criteria. 4. Complete element 240 to obtain potential third party liability and review month services.

Coverage Code (Review Schedule Items J and P)	In State Plan (Check ✓)	Medicaid Eligibility Coverage Requirement	Verification Instructions
02		SSI/SSP recipients who became ineligible for Title XVI cash assistance due solely to RSDI cost-of-living increases after April, 1977.	1. Verify that the individual became ineligible for Title XVI cash assistance after April, 1977 solely because of an RSDI cost-of-living increase under element 530. 2. Complete elements 110, 130, and 160 to verify SSI categorical relationship as of the review month. 3. Complete elements 140, 170, 210-260, 310-370, and 410-430 to verify eligibility for SSI, ignoring the amount of any RSDI cost-of-living increases after April, 1977 when doing computations. Use SSI eligibility worksheet. 4. Complete element 240 to obtain potential third party liability and review month services.

Coverage Code (Review Schedule Items 7 and 8)	In State Plan (Check ✓)	Medicaid Eligibility Coverage Requirement	Verification Instructions
03		Individuals who receive SSI basic payments where the State determines Medicaid eligibility using criteria more stringent than SSI requirements.	1. Complete element 160 to verify that SSI beneficiary had been certified as Medicaid eligible by the State, if applicable. 2. Complete element 180, 210-260, 310-370, and 410-440, as appropriate, for the more restrictive State requirements. 3. Complete element 240 to obtain potential third party liability and review month services.
04		Beneficiaries who receive mandatory State supplement payments only and the State determines Medicaid eligibility.	1. Complete elements 110, 120, 130, and 160 to verify SSI categorical relationship as of the review month. 2. Complete elements 140, 170, 210-260, 310-370, and 410-430 to verify financial eligibility for mandatory supplement. 3. Verify that beneficiary has received mandatory payments continuously from December, 1973, through the review month. 4. Complete element 240 to obtain potential third party liability and review month services.

Coverage Code (Review Schedule Items J and P)	In State Plan (Check ✓)	Medicaid Eligibility Coverage Requirement	Verification Instructions
05		Individuals who received Title II (RSDI) increase in August, 1972, and would otherwise be eligible for cash assistance and were either: a. Eligible for cash assistance under Titles I, X, XIV, or XVI in August, 1972; b. Would have been eligible for cash assistance in August, 1972, except for institutionalization; c. Would have been eligible for cash assistance except for cost of living increases in RSDI benefits paid under Title II.	1. Complete element 530 to verify receipt of Title II benefits in August, 1972. 2. a. Complete element 530 to verify actual receipt of Titles I, X, XIV, or XVI in August, 1972; b. On a separate set of worksheets, complete elements 110, 120, 130, 140, 160, 170, 210-260, 310-370, and 410-430 to verify potential cash assistance eligibility as of August, 1972, except for institutionalization, and document that finding under element 530 on the set of worksheets completed for the review month. 3. Complete elements 110, 130, and 160 to verify SSI categorical relationship as of the review month. 4. Complete elements 140, 170, 210-260, 310-370, and 410-430 to verify eligibility for SSI, ignoring the amount of the August, 1972, Title II increase (element 320) when doing computations. Use SSI eligibility worksheet. 5. Complete element 240 to obtain potential third party liability and review month services.

Coverage Code (Review Schedule Items J and P)	In State Plan (Check ✓)	Medicaid Eligibility Coverage Requirement	Verification Instructions
06		Persons who were eligible for Medicaid in December, 1973, as an "essential spouse" of a cash assistance beneficiary, and who continue to meet December, 1973, criteria.	1. a. Complete element 530 to verify actual status of the beneficiary as an essential spouse in December, 1973; b. On a separate set of worksheets, complete program areas 100-400 to verify potential status of the beneficiary as an essential spouse in December, 1973, and document that finding under element 530 on the set of worksheets completed for the review month. 2. Complete elements 110, 120, 130, 140, 160, and 170 to verify that the beneficiary was an essential spouse during the review month. 3. Complete element 530 to verify that status as an essential spouse was continuous from December, 1973, through the review month. 4. Complete element 240 to obtain potential third party liability and review month services.

Coverage Code (Review Schedule Items J and P)	In State Plan (Check ✓)	Medicaid Eligibility Coverage Requirement	Verification Instructions
07		Persons who were eligible for Medicaid in December, 1973, who would have been eligible for cash assistance at that time except for institutionalization, and who continue to meet December, 1973, criteria.	1. Complete element 140 to document institutionalization in December, 1973. 2. a. Complete element 530 to verify that the beneficiary was certified eligible for Medicaid in December, 1973; b. Complete elements 110, 120, 130, 140, 160, 170, 210-260, 310-370, and 410-430 to verify potential eligibility for Medicaid in December, 1973, and document that finding under element 530 on the set of worksheets completed for the review month. 3. Complete elements 110, 120, 130, and 160 to verify SSI categorical relationship as of the review month. 4. Complete elements 140, 170, 210-260, 310-370, and 410-430 to verify financial eligibility for Medicaid as of the review month, based on December, 1973, criteria, except for institutionalization (element 140). 5. Verify in element 530 that institutionalization was continuous between December, 1973, and the review month. 6. Complete element 240 to obtain potential third party liability and review month services.

Coverage Code (Review Schedule Items J and P)	In State Plan (Check ✓)	Medicaid Eligibility Coverage Requirement	Verification Instructions
08		Persons who were eligible for Medicaid in December, 1973, as blind or disabled, and who continue to meet the December, 1973, criteria.	1. Complete element 120, 130, 140, and 160 for the service period to verify that the beneficiary meets December, 1973, blindness or disability criteria. 2. Complete elements 140, 170, 210-260, 310-370, and 410-430 to verify financial eligibility for Medicaid, based on December, 1973, criteria, as of the review month. 3. Verify in element 530 that financial eligibility for Medicaid, based on December, 1973, criteria, was continuous between December, 1973, and the review month. 4. Complete element 240 to obtain potential third party liability and review month services.
21		Individuals who receive State optional supplement payments only where the State determines Medicaid eligibility using SSI criteria.	1. Verify that the beneficiary received an SSI optional supplement only during the review month and records that amount under element 330. 2. Complete elements 110, 120, 130 and 160 to verify SSI categorical relationship. 3. Complete elements 140, 170, 210-260, 310-370, and 410-430 to verify financial eligibility for Medicaid based on Title XVI financial criteria.

Coverage Code (Review Schedule Items J and P)	In State Plan (Check ✓)	Medicaid Eligibility Coverage Requirement	Verification Instructions
21 (Continued)			4. Complete element 240 to obtain potential third party liability and review month services.
22		Individuals who receive SSI optional supplement payments only where the State determines Medicaid eligibility using criteria which are more stringent than SSI requirements.	1. Verify that the beneficiary received an SSI optional supplement during the review month and record amount under element 330. 2. Complete elements 110, 120, 130, and 160 to verify SSI categorical relationship, utilizing State set requirements. 3. Complete elements 140, 170, 210-260, 310-370, and 410-430 to verify financial eligibility for Medicaid based on State set financial criteria. 4. For any State set requirements not covered above, verify under element 180. 5. Complete element 240 to obtain potential third party liability and review month services.
23		Persons who are eligible for SSI payments or a State supplement payment only, but are not receiving payments.	1. Complete elements 110, 120, 130, 140, 160, 170, 210-260, 310-370, and 410-430 for the review month to verify that the beneficiary would have been eligible for an SSI basic payment

Coverage Code (Review Schedule Items J and P)	In State Plan (Check ✓)	Medicaid Eligibility Coverage Requirement	Verification Instructions
23 (Continued)		Individuals who are determined to be eligible for medical assistance and who, on a retroactive basis, would have been eligible for such assistance for any medical services received in or after the third month before the month application was made.	or State supplement only, had the beneficiary applied. Use the SSI budget worksheet, as required. 2. Complete element 240 to obtain potential third party liability and review month services.
24		Individuals for whom a notice of ineligibility for SSI benefits is received after the tenth of the previous month, and who are eligible for coverage through the end of the following month while the State is in the process of determining continued eligibility for Medicaid.	1. Complete element 180 to document termination from SSI after the tenth of the month before the review month. 2. Complete element 540 to document that the State agency was still redetermining Medicaid eligibility under State designated criteria during the review month. 3. Complete element 240 to obtain potential third party liability and review month services.
25		Individuals residing in medical institutions with income sufficient for personal needs while in the institution, but who would be eligible for SSI or a State supplement payment if not living in the institution.	1. Complete element 140 to verify institutionalization during the review month. 2. Complete elements 110, 120, 130, and 160 to verify SSI categorical relationship as of the review month. 3. Complete element 440 for beneficiary liability determination.

Coverage Code (Review Schedule Items J and P)	In State Plan (Check ✓)	Medicaid Eligibility Coverage Requirement	Verification Instructions
25 (Continued)			4. Complete elements 140, 170, 210-260, 310-370, and 410-430 to verify eligibility for an SSI basic payment or State supplement payment assuming the beneficiary was not living in the institution. Use the SSI budget worksheet if required. 5. Complete element 240 to obtain potential third party liability and review month services.
26		Individuals whose eligibility for Medicaid has otherwise ceased, but who are still overcoming the effects of their eligibility condition.	1. Complete element 540 to document termination from SSI within two months prior to the review month. 2. Complete element 110 or 160 to verify that the beneficiary is overcoming the condition of Medicaid eligibility during the review month. 3. Complete element 240 to obtain potential third party liability and review month services.
27		Individuals who would be eligible for any of the SSI categorically needy groups listed above, except for excess income and/or resources and whose income is insufficient to meet medical expenses.	1. Complete sections 110, 120, 130, and 160 to verify SSI categorical relationship as of the review month. 2. Complete elements 140, 170, 210-260, 310-370, and 410-430, to verify financial eligibility for Medicaid except for excess income (program area 300).

Coverage Code (Review Schedule Items J and P)	In State Plan (Check ✓)	Medicaid Eligibility Coverage Requirement	Verification Instructions
27 (Continued)			3. Complete element 440 and the related beneficiary liability worksheet. 4. Complete element 240 to obtain potential third party liability and review month services.
28		Persons in a medical or intermediate care facility who, if they left the facility, would not be beneficiaries of optional State supplementary payments, but while in the facility are eligible under this plan.	1. Complete sections 110, 120, 130, and 160 to verify SSI categorical relationship as of the review month. 2. Complete elements 140, 170, 210-260, 310-370, and 410-430, to verify financial eligibility for Medicaid except for excess income (program area 300). 3. Complete element 440 and the related beneficiary liability worksheet to verify that the beneficiary had incurred appropriate medical expenses at the time of eligibility certification. 4. Complete element 240 to obtain potential third party liability and review month services.

Coverage Code (Review Schedule Items J and P)	In State Plan (Check ✓)	Medicaid Eligibility Coverage Requirement	Verification Instructions
41		Members of AFDC families who are eligible for four calendar months of medical service beginning with the month in which such families became ineligible for cash assistance due to increased hours of work or increased earned income.	1. Complete element 330 to verify actual receipt of AFDC cash payments in three of the six months prior to the review month. 2. Complete element 310 to document excess income or increased hours of employment which were the basis for AFDC termination. 3. Complete element 180 to verify that the date of AFDC ineligibility was within four months of the review month and some family member was employed from the date of AFDC ineligibility to the review month. 4, Complete element 180 to verify that the family or recipient did not become ineligible during the four month period for reasons other than increased earnings or hours of employment. 5. Complete element 240 to obtain potential third party liability and review month services.
42		Individuals under 21 who would be eligible for AFDC payments except for age or school attendance requirements.	1. Complete elements 110-150 to verify AFDC categorical relationship, ignoring State set age or school attendance requirements. 2. Complete elements 210-260, 310-370, 410-430, and 510-520 for the review month to verify financial eligibility for AFDC.

Coverage Code (Review Schedule Items J and P)	In State Plan (Check ✓)	Medicaid Eligibility Coverage Requirement	Verification Instructions
42 (Continued)			3. Complete element 240 to obtain potential third party liability and review month services.
43		Beneficiaries who are receiving AFDC foster care payments.	1. Verify that the beneficiary received an AFDC foster care payment in the review month and document in element 330. 2. Verify eligibility for an AFDC foster care payment through verifying elements 110-150. 3. Complete element 240 to obtain potential third party liability and review month services.
44		Individuals who received Title II (RSDI) increase in August, 1972, and would otherwise be eligible for cash assistance, and were either: a. Eligible for cash assistance under Title IV-A in August, 1972; b. Eligible for cash assistance in August, 1972,	1. Complete element 530 to verify receipt of Title II benefits in August, 1972. 2. a. Complete element 530 to verify actual receipt of AFDC benefits in August, 1972; b. On a separate set of worksheets complete elements 110-150, 210-260, 310-370, 410-430, and 510-520 to verify potential cash assistance eligibility as of August, 1972, except for insti-

Coverage Code (Review Schedule Items J and F)	In State Plan (Check ✓)	Medicaid Eligibility Coverage Requirement	Verification Instructions
44 (Continued)		except for institutionalization; c. Eligible for cash assistance except for cost of living increases in RSDI benefits paid under Title II.	tutionalization, and document that finding under element 530 on the set of worksheets completed for the review month. 3. Complete elements 110-150 to verify AFDC categorical relationship as of the review month. 4. Complete elements 210-260, 310-370, 410-430, and 510-520 to verify eligibility for AFDC, ignoring the amount of the August, 1972, Title II increase (element 320) when doing computations. 5. Complete element 240 to obtain potential third party liability and review month services.
45		Members of AFDC families who receive cash payments.	1. Elements of eligibility will have been verified by AFDC-QC for eligible cases. Cases found to be ineligible for cash payments should be checked for eligibility under other appropriate coverage codes. 2. Complete element 240 to obtain potential third party liability and review month services.

Coverage Code (Review Schedule Items J and P)	In State Plan (Check ✓)	Medicaid Eligibility Coverage Requirement	Verification Instructions
61		Beneficiaries who are receiving AFDC payments under special program provisions which are not covered by the existing AFDC-QC system: AFDC Emergency Assistance. (State review optional)	1. Verify that the beneficiary received an AFDC Emergency Assistance payment in the review month and document in element 330. 2. Verify AFDC categorical relationship for elements 110-150. 3. Verify financial eligibility for Medicaid on elements 210-260, 310-370, 410-430, and 510-520. 4. Complete element 240 to obtain potential third party liability and review month services.
62		Beneficiaries who are receiving AFDC payments under special program provisions which are not covered by the existing AFDC Presumptive Eligibility. (State review optional)	1. Verify that the beneficiary received an AFDC payment in the review month based on AFDC presumptive eligibility and document in element 330. 2. Verify AFDC categorical relationship for elements 110-150. 3. Verify financial eligibility for Medicaid on elements 210-260, 310-370, 410-430, and 510-520. 4. Complete element 240 to obtain potential third party liability and review month services.

Coverage Code (Review Schedule Items J and P)	In State Plan (Check ✓)	Medicaid Eligibility Coverage Requirement	Verification Instructions
63		Individuals who are a caretaker (or a spouse of a caretaker) who are caring for a child under 21 who would be eligible for AFDC except for age or school attendance requirements.	1. Complete element 140 to verify living arrangement of child with caretaker. 2. Complete elements 110-150 to verify AFDC categorical relationship, ignoring State set age or school attendance requirements. 3. Complete elements 210-260, 310-370, 410-430, and 510-520 for the review month to verify financial eligibility for AFDC. 4. Complete element 240 to obtain potential third party liability and review month services.
64		Persons who would be eligible for AFDC benefits but are not receiving payments.	1. Complete elements 110-150, 210-260, 310-370, 410-430, and 510-520 to verify that the beneficiary would have been eligible for an AFDC payment during the review month, had the beneficiary applied. 2. Complete element 240 to obtain potential third party liability and review month services.

Coverage Code (Review Schedule Items J and P)	In State Plan (Check ✓)	Medicaid Eligibility Coverage Requirement	Verification Instructions
65		Individuals who would be eligible for AFDC payments if they did not receive child care services through the agency, but had to pay for child care costs from earnings.	1. Verify that child care was received from the agency during the review month and verify the cost of the service received in sub-element 521. 2. Complete elements 110-150, 210-260, 310-370, 410-430, and 510-520 to verify that the beneficiary would have been eligible for an AFDC payment during the review month, if the estimated cost of child care services received (element 521) was treated as an income deduction in element 420. 3. Complete element 240 to obtain potential third party liability and review month services.
66		Persons who would be eligible for AFDC payments except that the State imposes eligibility conditions more stringent than or in addition to those in the Social Security Act.	1. In element 540, list the State established AFDC eligibility requirements which are more stringent or in addition to those in the Social Security Act. 2. Complete elements 110-150, 210-260, 310-370, 410-430, and 510-520 to verify potential AFDC eligibility during the review month. For each requirement listed in element 540, utilize the eligibility requirement as specified in the Social Security Act as the basis for the eligibility determination.

Coverage Code (Review Schedule Items J and P)	In State Plan (Check ✓)	Medicaid Eligibility Coverage Requirement	Verification Instructions
66 (Continued)			3. Complete element 240 to obtain potential third party liability and review month services.
67		Individuals residing in a medical institution with income sufficient for personal needs while in the institution, but who would be eligible for AFDC if they were not living in the institution.	1. Complete element 140 to verify institutionalization during the review month. 2. Complete elements 110, 120, 130, and 150 to verify AFDC categorical relationship as of the review month. 3. Complete elements 210-260, 310-370, 410-430, and 510-520 to verify eligibility for AFDC, assuming the beneficiary was not living in the institution. 4. Complete element 240 to obtain potential third party liability and review month services. 5. Complete element 440 for beneficiary liability determination.
68		Individuals whose eligibility for Medicaid has otherwise ceased, but who are still overcoming the effects of their eligibility condition.	1. Complete element 540 to document termination from AFDC within two months prior to the review month. 2. Complete element 150 to verify that the beneficiary is overcoming the condition of Medicaid eligibility during the review month.

Coverage Code (Review Schedule Items J and P)	In State Plan (Check ✓)	Medicaid Eligibility Coverage Requirement	Verification Instructions
68 (Continued)			3. Complete element 240 to obtain potential third party liability and review month services.
69		Individuals who would be eligible for any of the AFDC categorically needy groups listed above, except for excess income/resources, and whose income/resources are insufficient to meet medical expenses.	1. Complete sections 110-150 to verify AFDC categorical relationship as of the review month. 2. Complete elements 210-260, 310-370, 410-430, and 510-520, to verify financial eligibility for Medicaid, except for excess income (program area 300). 3. Complete element 440 and the related beneficiary liability worksheet to verify that the beneficiary had incurred appropriate medical expenses at the time of eligibility certification. 4. Complete element 240 to obtain potential third party liability and review month services.
81		Individuals under 21 who meet the AFDC income and resource limits, but do not meet the definition of dependent child under the AFDC program, or reasonable groups thereof.	1. Complete element 110 to verify age. 2. Complete elements 120, 130, 140, and 180 (if required) to verify that the child is in a State approved classification.

Coverage Code (Review Schedule Items J and P)	In State Plan (Check ✓)	Medicaid Eligibility Coverage Requirement	Verification Instructions
81 (Continued)			3. Complete elements 210-260, 310-370, and 410-430 to verify financial eligibility for Medicaid. 4. Complete element 240 to obtain potential third party liability and review month services.
82		Individuals who would be eligible for Medicaid as a needy individual under 21 except for excess income and/or resources and whose income is insufficient to meet medical expenses.	1. Complete element 110 to verify age. 2. Complete sections 120, 130, 140, and 180 (if required) to verify that the child is in a State approved classification. 3. Complete elements 210-260, 310-370, and 410-430 to verify financial eligibility for Medicaid, except for excess income (program area 300). 4. Complete element 440 and the related beneficiary liability worksheet to verify that the beneficiary had incurred appropriate medical expenses at the time of eligibility certification. 5. Complete element 240 to obtain potential third party liability and review month services.

3480 WORKSHEETS: ELIGIBILITY AND IDENTIFICATION OF POTENTIAL THIRD PARTY LIABILITY

The QC worksheets shown in this section are designed to accommodate all three types of categorical relationships under which beneficiaries may be reviewed: AFDC related; SSI related; and needy individuals under 21. The worksheets are attached to the facesheet and are used by the QC reviewer to record his analysis and evaluation for each step of the independent, full investigation carried out to determine eligibility under the State plan. Columns (2), findings from the case record review, and (3), findings from the field investigation, must carry sufficient information to permit the reviewer to make conclusions regarding errors and to complete Columns (4), (5), and (6). These worksheets also provide the basis for completing sections of the Review Schedule.

Entries on the worksheets must reflect the specifics of the investigation as conducted by the QC reviewer. Information on the worksheets provides substantiation of the findings on eligibility. Recording should be concise but sufficient to establish the facts on which the reviewer based his decision on each relevant element.

The document source, date and content should be recorded when documentary evidence is cited. When a person is used as a collateral source of information, his name should be recorded along with his significance to the investigation (e.g., landlord, employer, married daughter living out of home). When correspondence is used for verification, a copy should be attached or the relevant content summarized on the worksheet and the date given. Whatever method of verification is used, the reviewer's statement on the worksheet should show the sources of information he used, the information he secured, and how he arrived at a conclusion.

Space on the worksheets is limited. Only essential facts should be recorded. If space on the form is insufficient for any item, continue the entry on the back of the page. The recording must cover both the method used for verification and the information secured by this method.

3481 Elements Of Eligibility Determination (Column 1)

This column lists the elements which are known to be common prerequisites for Medicaid eligibility in most State plans. Definitions of the elements in relation to QC are found in Subchap 3460. States may add, under each of the program areas, any additional State eligibility requirements not included herein. The numbering system under each of the program areas will accommodate this expansion.

All elements of eligibility will not be completed for each beneficiary reviewed. Subchap 3470 summarizes the required elements to be verified for each Medicaid eligibility coverage group. Except where additional State plan provisions are involved, Subchap 3470 element requirements must be followed. Prior to conducting QC reviews in a State, the reviewer must study the State plan and identify those coverage groups applicable in that State.

3482 QC Analysis Of Case Record (Column 2)

The primary purpose of Column 2 is to assist the QC reviewer in planning for the field investigation, based on information available from agency records. Details of recorded information which do not need to be reverified will be entered in this column. Pertinent facts should be noted, as well as whether any facts, methods or conclusions are under question. Conflicts in recorded information, factors subject to change, reliability of sources used, and gaps in coverage should also be noted.

Column 2 should also be used for recording the information required in Sections I and II of the Review Schedule. The reviewer should be familiar with the specific information required for the Review Schedule (shown in Subchap 3490) which might be available in the case record. This familiarity will ensure that such information is obtained during the review of the case record.

Column 2 may also be used selectively to highlight other points for consideration in the field, or to enter information which will serve to remind the reviewer of the beneficiary's situation.

3483 Findings Of Field Investigation (Column 3)

The factual results of the field investigation, as they relate to each program area, are recorded in Column 3 of the Worksheets. Information in this column provides the basis for completing and supporting coded information in Item M of the Review Schedule. Any questions raised in Column 2 will be answered here. Entries such as "correct," "verified," and "OK" do not constitute adequate recording. The entries to be made in this column will relate only to the facts of the situation affecting eligibility as of the review month and to the existence of potential third party liability.

The reviewer must, on all applicable elements as determined by the Verification Guide, note the specific sources used to verify, document or attempt to verify the element. For example, when the reviewer has pursued the possibility of resources with the beneficiary and appropriate collateral sources and finds no evidence of a resource, he makes a decision and records on the worksheet a summary of the basis for his decision.

Where there are eligibility errors, the date the errors first occurred should be recorded. Changes in circumstances before or after the review month would not be regarded as errors if eligibility was not affected as of the review month. These should, however, be brought to the attention of the local agency according to State procedure.

3484 Summary Findings (Columns 4, 5, and 6)

Summary findings for all elements will be checked in either Column 4, 5, or 6. Column 4 is checked whenever (a) the element is not pertinent to the eligibility coverage requirement in question, or (b) there is no error for the element when it is verified. When Column 4 is checked, Columns 5 and 6 will not be checked.

Column 5 or 6 will be checked whenever there is an error for the element under review. By definition, there may be only one eligibility error per numbered element or sub-element on the worksheets. Column 5 or 6 is checked in accordance with the instructions for coding agency and beneficiary error on the Review Schedule (Subchap 3492). If an eligibility error is due to both the agency and the beneficiary, only Column 5 (agency) should be checked.

3485 Supplemental Worksheets

To facilitate documentation of review findings, five supplemental worksheets have been developed and should be utilized by the QC reviewer as appropriate. The supplemental worksheets are as follows:

1. Case liability worksheet - This one page case liability worksheet can be used for reviewing the liability computations of those cases with excess income/resources which have been certified eligible for Medicaid based on an agency determination that the excess income/resources will be needed to meet an equal amount of incurred medical expenses. (Subchap 3463 instructions for Element 440 lists applicable groups).

Excess income/resources are determined by subtracting the State's allowable income/ resources level from the case's countable income.

Countable income for liability computations which differs from the countable income used to determine financial eligibility under element 430 is defined as follows for the indicated cases:

Institutional cases - All income including amounts disregarded in eligibility determination unless otherwise provided for in State plan.

Non-Institutional cases - Net income available after deduction of applicable disregards.

The case liability worksheet is structured to facilitate a comparison of the State agency's computations of case liability with the similar QC computations. From agency records, the QC reviewer should record (1) the date that the liability period (including the review month) begins, (2) the number of months in the liability period, and (3) the date that the agency shows liability was met and certifies Medicaid eligibility. Also, from the agency records, the QC reviewer should record the agency computations of case liability in the "Computation from Agency Case Record" column of the worksheet.

After verifying beneficiary (ies) income and resources, determining the correct State allowable maintenance level, and reviewing the incurred expenses used by the agency to offset excess income, the QC reviewer should record his own computations of case liability in the "QC Computation" column of the worksheet. If the QC reviewer's computations differ from the agency's computations, then either a "case liability understated" or a "case liability overstated" error has occurred.

The findings on which the QC reviewer based his computations in the "QC Computation" column of the Case Liability Worksheet should be recorded under element 440, including a description of the types and dollar amount of services incurred to offset excess income which are documented in agency records. The reviewer should also record the reasons for

any case liability errors. However, if the only reason for a case liability error is unreported income, the error should only be coded as an error on the Worksheet for program area 300. In States which permit beneficiaries to use medical expenses to offset excess liquid resources, if the only reason for a case error is unreported excess resources, the error should only be coded as an error on the Worksheet for program area 200.

If the reviewer is unable to verify from agency records or the beneficiary (ies) during the field investigation whether or not a case subject to liability requirements had incurred the appropriate dollar amount of medical expenses as of the date of certification, the reviewer should code a case liability error (element 440). Only the "QC Computation" column of the case liability worksheet would be completed in this instance.

2. SSI eligibility worksheet (optional) - If the basis for Medicaid eligibility of the beneficiary is potential eligibility for SSI benefits, the SSI eligibility worksheet may be used to record computations, at the discretion of the reviewer. The State may utilize its own SSI budget worksheet if a form is available.

   If the SSI eligibility worksheet is utilized, computations should be done in accordance with the SSI Claims Manual.

3. Medical services and health benefits worksheet supplement - This supplement is to be used by the eligibility QC/QA reviewers to capture specific information on, and indications of, third party liability and medical services received by case members during the review month. Specific instructions for completing the supplement are contained in Subchap 3487.

3486 Worksheets

The eligibility and supplemental worksheets are presented on the following pages.

MEDICAID QUALITY CONTROL WORKSHEET:
ELIGIBILITY AND TPL IDENTIFICATION

Review No._____

ELEMENTS OF ELIGIBILITY DETERMINATION	QC ANALYSIS OF CASE RECORD (Pertinent Facts, Sources of Verification, Reliability, Gaps, or Deficiencies)	FINDINGS OF FIELD INVESTIGATION (Facts Obtained, Verification and Substantiation, Nature of Errors)	SUMMARY (Check One)			ELEMENT CODE
				Error		
			No Error/ Not Applicable	Agency	Beneficiary	
(1)	(2)	(3)	(4)	(5)	(6)	
	BASIC PROGRAM REQUIREMENTS (100)					
110 Age						110
120 Citizenship/Alienage						120
130 Residency						130
140 Living Arrangement (Include institutionalization and living with specified relative)						140

Review No._____

ELEMENTS OF ELIGIBILITY DETERMINATION	QC ANALYSIS OF CASE RECORD (Pertinent Facts, Sources of Verification, Reliability, Gaps, or Deficiencies)	FINDINGS OF FIELD INVESTIGATION (Facts Obtained, Verification and Substantiation, Nature of Errors)	SUMMARY (Check One)			ELEMENT CODE
			No Error/ Not Applicable	Error: Agency	Error: Beneficiary	
(1)	(2)	(3)	(4)	(5)	(6)	
150 Deprivation (circle one)						150
151 Death						151
152 Incapacity						152
153 Continued absence						153
154 Unemployed father						154
160 Blindness/ Disability Determination						160
170 Marital Status						170
180 Other Categorical Relationships (Include Needy Individual Under 21)						180

Review No. _____

ELEMENTS OF ELIGIBILITY DETERMINATION	QC ANALYSIS OF CASE RECORD (Pertinent Facts, Sources of Verification, Reliability, Gaps, or Deficiencies)	FINDINGS OF FIELD INVESTIGATION (Facts Obtained, Verification and Substantiation, Nature of Errors)	SUMMARY (Check One)			ELEMENT CODE
			No Error/ Not Applicable	Error		
				Agency	Beneficiary	
(1)	(2)	(3)	(4)	(5)	(6)	
210 Real Property (Home and other)	RESOURCES (200)					210
220 Liquid Assets						220
221 Cash on hand						221
222 Bank accounts						222
223 Stocks & bonds						223
224 Other						224
230 Life Insurance						230

Review No._____

ELEMENTS OF ELIGIBILITY DETERMINATION	QC ANALYSIS OF CASE RECORD (Pertinent Facts, Sources of Verification, Reliability, Gaps, or Deficiencies)	FINDINGS OF FIELD INVESTIGATION (Facts Obtained, Verification and Substantiation, Nature of Errors)	SUMMARY (Check One)			ELEMENT CODE
			No Error/ Not Applicable	Error: Agency	Error: Beneficiary	
(1)	(2)	(3)	(4)	(5)	(6)	
240 Medical Insurance	(See Supplemental TPL Worksheet)					240
241 Medical Services						
242 Accident Related TPL						

Review No.

ELEMENTS OF ELIGIBILITY DETERMINATION	QC ANALYSIS OF CASE RECORD (Pertinent Facts, Sources of Verification, Reliability, Gaps, or Deficiencies)	FINDINGS OF FIELD INVESTIGATION (Facts Obtained, Verification and Substantiation, Nature of Errors)	SUMMARY (Check One)			ELEMENT CODE
			No Error/ Not Applicable	Error: Agency	Error: Beneficiary	
(1)	(2)	(3)	(4)	(5)	(6)	
250 Other Personal Property (Include motor vehicle and any other resources)						250
260 Disposal of Property						260

Review No. _____

ELEMENTS OF ELIGIBILITY DETERMINATION	QC ANALYSIS OF CASE RECORD (Pertinent Facts, Sources of Verification, Reliability, Gaps, or Deficiencies)	FINDINGS OF FIELD INVESTIGATION (Facts Obtained, Verification and Substantiation, Nature of Errors)	SUMMARY (Check One)			ELEMENT CODE
			No Error/ Not Applicable	Error: Agency	Error: Beneficiary	
(1)	(2)	(3)	(4)	(5)	(6)	
310 Earned Income						310
320 RSDI Benefits (Social Security)						320
330 Benefits from Other Government Programs						330
331 Veterans benefits						331
332 Unemployment Comp.						332
333 Workmen's Comp.						333
334 SSI						334
335 Other						335

Review No.

ELEMENTS OF ELIGIBILITY DETERMINATION	QC ANALYSIS OF CASE RECORD (Pertinent Facts, Sources of Verification, Reliability, Gaps, or Deficiencies)	FINDINGS OF FIELD INVESTIGATION (Facts Obtained, Verification and Substantiation, Nature of Errors)	SUMMARY (Check One)			ELEMENT CODE
			No Error/ Not Applicable	Error: Agency	Error: Beneficiary	
(1)	(2)	(3)	(4)	(5)	(6)	
340 Pensions or Other Benefits						340
350 Support Payments						350
360 Income, In-Kind or Deemed						360
370 Other Income						370

Review No._____

ELEMENTS OF ELIGIBILITY DETERMINATION	QC ANALYSIS OF CASE RECORD (Pertinent Facts, Sources of Verification, Reliability, Gaps, or Deficiencies)	FINDINGS OF FIELD INVESTIGATION (Facts Obtained, Verification and Substantiation, Nature of Errors)	SUMMARY (Check One)			ELEMENT CODE
			No Error/ Not Applicable	Error: Agency	Error: Beneficiary	
(1)	(2)	(3)	(4)	(5)	(6)	
410 Computations of Income (Include Disregards)						410
420 Deductions to Countable Income						420
430 Arithmetic Computations						430
440 Beneficiary Liability Determination Note: Record income errors only in 300 areas		(See Case Liability Worksheet)				440

Review No.

ELEMENTS OF ELIGIBILITY DETERMINATION	QC ANALYSIS OF CASE RECORD (Pertinent Facts, Sources of Verification, Reliability, Gaps, or Deficiencies)	FINDINGS OF FIELD INVESTIGATION (Facts Obtained, Verification and Substantiation, Nature of Errors)	SUMMARY (Check One)			ELEMENT CODE
			No Error/ Not Applicable	Error: Agency	Error: Beneficiary	
(1)	(2)	(3)	(4)	(5)	(6)	
510 AFDC Related Budgetary Allowances	OTHER MEDICAID COVERAGE REQUIREMENTS (500)					510
520 AFDC Related Special Needs						520
521 Child Care						521
522 Transportation						522
523 Work Expenses						523
524 Personal Care						524
525 Other						525
530 Grandfathered Coverage Provisions						530
540 Other State Medicaid Criteria						540

Form HCFA-301 B (3/78)
Department of Health, Education and Welfare
Health Care Financing Administration

OMB No. 066-R-0107
Expires 3/79

Review No._____

MEDICAID QUALITY CONTROL CASE LIABILITY WORKSHEET
(Appropriate State form may be substituted)

Case Name	Case ID Number
Accounting Period	Date Liability Met

		Computation from Agency Case Record	QC Computation
A.	Countable Income During Liability Period	$	$
B.	Allowable Maintenance Level During Liability Period		
C.	Amount of Excess Income (A-B)		
D.	Amount of Resources		
E.	Allowable Resources		
F.	Amount of Excess Resources (D-E)		
G.	Amount of Non-Liquid Resources Which Must be Disposed of		
H.	Amount of Liquid Resources Which Must be Applied		
I.	Total Excess Income and Resources Which Must be Obligated (C+F)		
J.	Medical Expenses Incurred for Period to Meet Liability		
K.	Net Dollar Amount (I-J) Should be Equal to Zero, if not, Error Exists		
L.	Dollar Amount of Case Liability Error		

1. Liability understated - amount K, Column 2, when net amount of I-J is positive and greater than $5.00

2. Liability overstated - amount K, Column 2, when net amount of I-J is negative and absolute value greater than $5.00

MEDICAID QUALITY CONTROL

SSI ELIGIBILITY WORKSHEET

(Note: Use State budget form instead, if available) Review No. _____

Eligibility Reviewed for: Eligible Individual ☐
Member of Eligible Couple ☐

Living Arrangement of Beneficiary as of Review Month

- In Own Household (or household of parent) ☐
- In Household of Another ☐
- In Public Title XIX Institution, Medicaid covers more than 50% of Costs ☐
- In public Title XIX Institution, Medicaid covers 50% or less of Costs ☐
- In private Title XIX Institution, Medicaid covers more than 50% of Costs ☐
- In private Title XIX Institutions, Medicaid covers 50% or less of Costs ☐

(Compute on quarterly basis for calendar quarter including the review month)

1. Federal Standard Payment Amount
   (or higher State set income level, if applicable) + $_____

2. Earned Income
   (Specify)
   _____
   _____
   _____
   _____ - $_____

3. Unearned Income
   (Specify)
   _____
   _____
   _____
   _____ - $_____

4. Adjustments to Income
   (Specify)
   Note: adjustments must not surpass income category to which they apply.

   federal:
   $60 general exclusion _____
   $195 of earned income + 1/2 remainder _____
   _____
   _____
   _____

   state:
   _____

5. POTENTIAL SSI (AND STATE SUPPLEMENT) BENEFIT AMOUNT + $_____

   = $_____
   (if negative, set to 0)

RESERVED FOR

FUTURE

USE

3487 Instructions for completing the Medical Services and Health Benefits Worksheet Supplement

I. Identifying Information

The reviewer will supply the information required in the identifying information portion of the supplement. The reviewer will sign the form in the space provided upon completion:

1. Case Name and Address: The name given to the QC/QA case and the current residence address.

2. Category: Check the applicable category.

3. Case I.D. Number: Enter the number used by SSI or State agency to identify the case.

4. QC Number: The AFDC-QC, Review Number if care is selected from the AFDC stratum.

5. QAFO: The SSI Quality Assurance Field Office conducting the review if applicable.

6. State and County: The State and county from which the sample case was selected. This may differ from the beneficiaries' current residence.

7. Review/Sample Month: The month and year for which eligibility is being reviewed.

8. Date of Review: The day, month and year on which the reviewer conducted the field review.

9. Case Phone Number: Include area code for all beneficiaries' phone numbers shown. If no members of the case have a phone, indicate "NONE".

10. SSI Case Completion Status: This block is used by SSI-QA reviewer to report completion of the QA review. Not applicable in AFDC-QC or MAO reviews.

11. SSI Stratum Code: This block is only applicable to the SSI-QA sample. It will be used by the MQC statisticians.

Background information on the nature of different insurances and the circumstances where they would be available to a beneficiary is contained in Chapter 3500.

II. Health Insurance Coverage.

1. Check the appropriate box to indicate if the case had any health insurance or medical benefits available other than Medicaid. The reviewer should be familiar with potential sources. An example of additional questions is: Does your job have an insurance program for its employees? If a definite "no" is obtained the reviewer will not complete the remainder of I but proceed to II, Medical Services.

2. If any affirmative answer is obtained, the reviewer will indicate the source. Other government programs include CHAMPUS, and V.A. benefits. Other insurances could be H.M.O.'s, State programs. A description of different insurances is contained in Chapter 3500 of the MQC Manual.

3. For AFDC related beneficiaries, the reviewer will indicate if an absent parent has insurance to cover any members. If so, the name of the absent parent, the dependents covered, and the source of the insurance from number 2 is indicated.

4. For any insurance in force during the review month the reviewer will capture the necessary identifying information to include the extent of case coverage and the benefits available. Other coverage could be dental, optical, etc.

III. Medical Services

1. The reviewer will indicate if any health services were received by any case member during the review month.

2. Indicate the types of services received. Others could be home health services, transportation, nursing care.

3. Indicate the need for services. Others could be routine check-up, EPSDT.

4. If injury, indicate where the injury occurred. Others could be store, neighbor, restaurant. Identify the characteristics of the event and identify pertinent witnesses, employers, drivers, attorney representing the beneficiary if a court action is initiated.

Additional comments are used to give observations of the reviewer, and to provide explanations of earlier entries, so as to better inform the TPL and CP units. This portion of the supplement is to be used to record additional sources of insurance and additional identifications and pertinent information (i.e., CHAMPUS). This section will also be used

Department of Health, Education and Welfare
Health Care Financing Administration

OMB No. 066-R-0107
Expires 3/79

I IDENTIFYING INFORMATION Reviewer: _____

1. Case Name and Address	2. Category AFDC ☐ SSI ☐ MAO ☐	3. Case ID Number
	4. AFDC-QC Number	5. QAPO
	6. State and County	7. Review/Sample Month / 8. Date of Review
9. Case Phone Number	10. SSI Case Completion Status: Eligible ☐ Ineligible ☐ Excluded/Dropped ☐	11. SSI Stratum Code ☐ (1, 3, 5, FFL; 2, 4, 6 Non-FFL)

II HEALTH INSURANCE COVERAGE

1. Does any member of the case* have medical benefits available and/or health insurance coverage? (Other than Medicaid)
YES ☐ NO ☐ (if no, proceed to III)

2. If yes, from what source? (check each available source.)
A. Medicare .....(Part A) ☐ ..(Part B) ☐ Claim Number ID: _____
B. Other Government Programs ..... ☐ identify _____
C. Group Insurance ..... ☐
D. Personal Insurance ..... ☐
E. Other ..... ☐ identify _____

3. Are any of the above available through an absent parent? YES ☐ NO ☐ (if yes, complete 3)
+ Name of absent parent : _____
+ Name(s) of member(s) covered: _____
+ Source(s) of coverage : A ☐ B ☐ C ☐ D ☐ E ☐

4. Complete the following to identify source(s) of insurance and benefits. (omit Medicaid and Medicare)

Name of Carrier		
Name of Insured		
Group Name (if applicable)		
Group Number (if applicable)		
Policy Number		
Effective Date of Policy		
Coverage (check one) Self	☐	☐
Self & Spouse	☐	☐
Family	☐	☐
Benefits (check each available)		
Hospital	☐	☐
Surgical	☐	☐
Major Medical	☐	☐
Other	☐ identify _____	☐ identify _____

* Includes spouse in SSI case and parents of a child eligible for SSI.

Case Name	Case ID Number

III MEDICAL SERVICES

1. Did any member of the case receive medical services during the review/sample month? YES ☐ NO ☐
(if no, further entries are not required)

2. If yes, indicate type(s) of service(s).

A. Hospital Inpatient ..... ☐
B. Hospital Outpatient ..... ☐
C. Long Term Care Facility ..... ☐
D. Physician and/or Clinic ..... ☐
E. Dental and/or Optical ..... ☐
F. Drugs ..... ☐
G. Devices ..... ☐
H. Other(s) .....(identify below)..... ☐

3. Were services the result of: illness ☐ injury ☐ other ☐ ?

4. If services were the result of injury, where did the injury occur?

A. Automobile ..... ☐
B. Employment ..... ☐
C. School ..... ☐
D. Home ..... ☐
E. Other .....(identify)... ☐

Complete the following.

Date injury occurred : _____

Location/Address where injury occurred: _____

Name and Address of provider : _____

Type of injury (fracture, cut, etc.) : _____

Identify other parties involved : _____
(witnesses)
(other drivers)
(employer)
(attorney)
(business)
(home owner)
(etc.)

ADDITIONAL COMMENTS: _____

by SSI-QA reviewers when the current residence address (particularly the State or county) differs from the State in which the sample was selected.

3490 COMPLETION OF THE ELIGIBILITY QC REVIEW

After an appropriate case investigation, the QC reviewer must examine all evidence available to assure that a conclusive decision regarding the eligibility of the case can be made. Then the final step in the eligibility QC process is completing the Review Schedule. QC eligibility determinations and associated errors can be recorded at the completion of the eligibility review.

The remainder of this section presents: considerations in closing the eligibility review, instructions for completing the eligibility portions of the Review Schedule, and listings of error codes and other codes required for completing the Review Schedule.

3491 Closing The Eligibility Review

The reviewer's decision regarding the beneficiary's eligibility status requires conclusive verification and documentation of all appropriate elements of eligibility. The probative value of any record is a matter of judgment, but a sound judgment can be made by examining all the facts surrounding the establishment of the record. Consideration should be given to all of the following factors in determining the probative value of any evidence:

1. Age of evidence or date evidence was established.

2. Purpose for which established. (e.g., Would there have been any reason for falsification of the person's age?)

3. Basis for the record. (e.g., Was proof of the person's age requested; if not, who provided the date of birth information on the document?)

4. Formality of the record. (e.g., Was the record made under oath and witnessed? Was there a penalty stated for false statements?)

5. Custody of the document. (e.g., Has it been in the possession of anyone who might have had a reason to change it?)

6. Way in which the information is recorded. (e.g., Is the specific date of birth shown - or does it show only age and, if so, does it indicate last, next, or nearest birthday?)

When evaluating a document, all identifying information shown on the record (name, parents' name, place of birth) should be checked to make certain that it applies to the beneficiary under review. Any discrepancies between the record and other identifying information in the case record should be resolved. The number of pieces of secondary evidence which should be obtained will depend on evaluation of the factors shown above as they relate to information present in the case record.

When conclusive verification is not available, the QC reviewer must use secondary evidence to establish a basis for his decision. To illustrate, a beneficiary presents a family Bible to verify age. The reviewer must make a decision as to whether he will accept this verification by itself or seek other supporting evidence. Secondary evidence must be evaluated in terms of its consistency with other documented information, and State Medicaid eligibility policies.

In the investigation of certain beneficiaries, conclusive documentation may be limited or unavailable. The best information available may be inferences that can be drawn from the existing facts that have been verified. This is particularly true with respect to verifying negative responses, e.g., "I have no income," or "I have no cash on hand." These situations can be difficult to document or otherwise substantiate definitively.

In such instances, the full field investigation extends to a point that is considered by the reviewer to be reasonable and prudent. Based on cumulative evidence available and observation, the reviewer must make a judgment and base the review decision on this judgment. In these instances, the reviewer records the basis on which the judgment was made. The concurrence of the QC supervisor should be sought and will generally ensure that the evidence developed is adequate for substantiating the decision which was made.

In other instances, the reviewer will not be able to obtain documentation for all elements of eligibility but has sufficient information on which to document ineligibility. For MQC purposes, these are to be treated as complete reviews.

The reviewer will also consider as a completed review all of those cases where he found no evidence of Medicaid Eligibility Certification and coded the case as ineligible as instructed in Subchap 3394.

3492 Instructions For Review Schedule

A Quality Control Review Schedule is required for each MQC sampled case. (This specifically includes each completed eligible and ineligible case included in the AFDC and SSI-QA samples.) The worksheets must contain documentation for the information entered on the Review Schedule.

The first portion of the Review Schedule, shown following this page, is completed following the eligibility QC review.[1/] Items 1-7 provide identification and control information. Items A-T of Sections I, II, III, and IV will be completed by either checking a box or entering a number. Where a check is required, a State should use the boxes located in the upper right hand corner of the item for a numeric code which corresponds to the entry checked. Items A-T contain the data necessary for official sample reports.

I. Identifying Information

1. Case Name - Enter the full name of the head of the Medicaid Assistance Group.

2. Address - Enter the complete address where the case members resided at the time of the review.

3. Case Identification Number - Enter the number used by the State agency to identify the case.

4. Review Month - Enter the month and year for which case eligibility was reviewed.

5. Date Assigned - Enter the date (month, day, year) the case was assigned to the reviewer.

6. Date Completed - Enter the date (month, day, year) the reviewer has completed his investigation and has made the determination of case eligibility.

7. Reviewer - Enter the name of the reviewer. Names of additional reviewers should be entered below Item 7.

II. Case Information

All Items coded in II. Case Information, are recorded from the facesheet. Items A-D are provided to the QC reviewers. Items E-G will be determined from the case record. For SSI cases in 1634 States, complete as many items as possible from the identifying information Section I of the Medical Services and Health Benefits Worksheet Supplement. This information is also available to non-1634 States in SDX tapes.

1/ Other portions of the Review Schedule are completed after: the TPL, QC Reviews, the CP QC reviews, and the dollar values of errors are computed for the dollar amount of the paid claims.

Form HCFA-301 (3/78)
Department of Health, Education and Welfare
Health Care Financing Administration

OMB No. 066-R-0107
Expires 3/79

MEDICAID QUALITY CONTROL REVIEW SCHEDULE

Review No. _____

I. Identifying Information

1. Case Name	2. Address	3. Case ID Number

4. Review Month	5. Date Eligibility Review Assigned	6. Date Eligibility Review Completed	7. Reviewer

II. Case Information
(Card 1)

A. State Code (1 2)

B. Local Agency Code (3 4 5)

C. Review Number (6 7 8 9 10 11)

D. Review Mo. & Yr. (12 13 14 15)

E. Date of Most Recent Action (prior to date in item "D") Mo. (16 17) Yr. (18 19)

F. Type of Most Recent Action (20)
1. ☐ Approved Application
2. ☐ Redetermination

G. Number of Months between Most Recent Action and Review Month (If action concurrent with Review Month, enter 00) (21 22)

H. Categorical Relationship (check one) (23)
1. ☐ SSI Cash Assistance
2. ☐ AFDC Cash Assistance
3. ☐ Medically Needy
4. ☐ Other Non-Cash

I. Basis for Categorical Relationship (check one) (24)

SSI RELATED	AFDC RELATED	NEEDY INDIVIDUAL UNDER 21
1. ☐ Aged	4. ☐ Death	8. ☐ Foster care
2. ☐ Blind	5. ☐ Incapacity	9. ☐ Other
3. ☐ Disabled	6. ☐ Unemployed father	
	7. ☐ Continued absence	

J. Medicaid Eligibility Coverage Requirement Used by Agency (code) (25 26)

K. Number of Persons in Household (27 28)

L. Number of Persons in Medicaid Assistance Group (29 30)

M. Does the case record show the presence of any of the following elements during the Review Month?

(a) INCOME (31 32 33 34 35)			(b) RESOURCES (36 37 38 39 40)		
31 Earned Income	1 Yes ☐	2 No ☐	36 Real Property (home & other)	1 Yes ☐	2 No ☐
32 RSDI Benefits	1 Yes ☐	2 No ☐	37 Other Personal Property (motor vehicle & other)	1 Yes ☐	2 No ☐
33 Other Govt Benefit Programs	1 Yes ☐	2 No ☐	38 Life Insurance	1 Yes ☐	2 No ☐
34 Pensions or Other Benefits	1 Yes ☐	2 No ☐	39 Medical Insurance	1 Yes ☐	2 No ☐
35 Other Unearned Income	1 Yes ☐	2 No ☐	40 Liquid Assets	1 Yes ☐	2 No ☐

III. Eligibility Field Review Information

N. Did the field review show the presence of any of the following elements during the Review Month?

(a) INCOME (41 42 43 44 45)			(b) RESOURCES (46 47 48 49 50)		
41 Earned Income	1 Yes ☐	2 No ☐	46 Real Property (home & other)	1 Yes ☐	2 No ☐
42 RSDI Benefits	1 Yes ☐	2 No ☐	47 Other Personal Property (motor vehicle & other)	1 Yes ☐	2 No ☐
43 Other Govt Benefit Programs	1 Yes ☐	2 No ☐	48 Life Insurance	1 Yes ☐	2 No ☐
44 Pensions or Other Benefits	1 Yes ☐	2 No ☐	49 Medical Insurance	1 Yes ☐	2 No ☐
45 Other Unearned Income	1 Yes ☐	2 No ☐	50 Liquid Assets	1 Yes ☐	2 No ☐

IV. Eligibility Summary Findings

Form HCFA-301 Page 2 of 5 Review No. _____

O. Disposition of Review (check one) [51]

1. ☐ Review completed

If code 1 is checked, complete the remainder of Section IV below. If any other code is checked, no further entry is required.

Review not completed due to:

2. ☐ Moved out of State since Review Month
3. ☐ Unwilling to give information
4. ☐ Unable to locate
5. ☐ Listed in error
6. ☐ Other (explain)_____

P. For eligible cases, Medicaid eligibility coverage requirement used by reviewer (code) [52 53]

Q. Eligibility Review Findings

1a. Case Status [54]

1. ☐ Eligible
2. ☐ Ineligible
3. ☐ Eligible w/Ineligible Members
4. ☐ Liability Understated Error Only
5. ☐ Liability Overstated Error Only
6. ☐ Liability Understated Error w/Ineligible Member(s)
7. ☐ Liability Overstated Error w/Ineligible Member(s)

1b. Case Member Status

1. Eligible Members [55 56]
2. Ineligible Members [57 58]
3. Eligible Members with Understated Liability [59 60]
4. Eligible Members with Overstated Liability [61 62]

2. Number of Elements in Error [63 64]

R. Overall Dollar Amount of Liability Error (enter if error is $5.00 or more) [65 66 67 68 69]

S. Does there appear to be willful misrepresentation of facts? (check one) 1. Yes ☐ 2. No ☐ [70]

T. Description of Error(s) (Card 2: Duplicate columns 1-15 from card 1)

Error	Element	Nature	Type	Error Finding	# of Members with Error	Date Error Occurred Month	Date Error Occurred Year
1.	16 17 18	19 20	21 22	23	24 25	26 27	28 29
2.	30 31 32	33 34	35 36	37	38 39	40 41	42 43
3.	44 45 46	47 48	49 50	51	52 53	54 55	56 57
4.	58 59 60	61 62	63 64	65	66 67	68 69	70 71
(Card 3: Duplicate columns 1-15 from card 1)							
5.	16 17 18	19 20	21 22	23	24 25	26 27	28 29

V. Explanation of Eligibility Errors

(1) Elements	(2) Nature of Error(s)	(3) State Manual Citation

A. State Code - (To be supplied by State office; see Subchap 3493 for your State code.)

B. Local Agency Code - This item is provided for State use to identify the county, district or other geographic or administrative area that best serves the State's purpose.

C. Review Number - (To be supplied to the reviewer by the State office.) Enter the serial number assigned to this case.

D. Review Month and Year - The reviewer should enter the two digit code of the month and the last two digits of the year for which the sampled case was reviewed. This information is provided to the reviewer by the State office and should be transcribed on to the Review Schedule from the facesheet.

E. Date of Most Recent Action - Enter the most recent month and year in which the agency actually determined or redetermined the Medicaid eligibility of the case prior to the review month entered in Item D. The reviewer should enter the two digit code of the month and the last two digits of the year.

F. Type of Action - For the action identified in Item E, enter the appropriate type code as follows:

1. Approved Application (new or reopened case) - Approval means the agency's determination to certify a case eligible for Medicaid.

2. Redetermination - Redetermination means (a) a complete reexamination by the agency of all factors of eligibility following a period of time during which the case has been Medicaid eligible and (b) a decision to continue eligibility for Medicaid.

G. Number Of Months Between Most Recent Action and Review Month - This item will provide information for a distribution of reviews by number of months elapsed between the agency's last complete determination of eligibility (as checked in Item E) and the review month. It

will also provide a basis for comparison with the date error(s) occurred as coded in Item T. In doing the computation, do not count the month of the action but count the review month. If the most recent action is concurrent with the review month (e.g., review month is the same as the month of application or redetermination) enter [0|0].

H. Categorical Relationship - All Medicaid beneficiaries except needy individuals under 21 must have a categorical relationship to the SSI or AFDC cash assistance programs. A beneficiary must be aged, blind, disabled, or a member of a family with dependent children to be considered eligible. Check the appropriate box depending on the categorical relationship of the case.

I. Basis for Categorical Relationship - Check the basis for the case's categorical relationship as identified in the case record.

J. Medicaid Eligibility Coverage Requirement Used by Agency - Code the eligiblity coverage requirement used by the State as the basis for Medicaid eligibility, as evident in agency records. Use the appropriate eligibility coverage requirement code as listed in the Verification Guide.

If the coverage requirement used by the State as the basis for Medicaid eligibility can not be determined, code Item J as [9|9].

K. Numer of Persons in Household - Enter the number of persons in the household as recorded on the facesheet. Always enter two digits (e.g., [0|8]).

Household is defined in Subchap 3441 under the instructions for completing Section B of the facesheet.

L. Number of Persons in Medicaid Assistance Group - Enter the number of persons in the household who are also in the Medicaid Assistance Group. Always enter two digits (e.g., [0|5]).

The entry for Item L must correspond to the number of checks (✓) in Section B of the face-sheet.

(Note: The number entered in Item L cannot be larger than the number entered in Item K.)

M. Does the Case Record Show the Presence of any of the Following Elements During the Review Month?

(a) Income

Earned Income - Check the appropriate box to show if the case record indicates earned income from regular or irregular employment of the member(s) of the Medical Assistance Group during the review month.

RSDI Benefits - Check the appropriate box to show if the case record indicates receipt of Social Security benefits by member(s) of the Medical Assistance Group during the review month.

Other Government Program Benefits - Check the appropriate box to show if the case record indicates receipt of other government program benefits by the member(s) of the Medical Assistance Group during the review month.

Other government program benefits include Veterans Benefits, Unemployment Compensation Benefits, Workmen's Compensation Benefits, and SSI payments.

Pensions or Other Benefits - Check the appropriate box to show if the case record indicates the receipt of non government pensions or other benefits by the member(s) of the Medical Assistance Group during the review month.

Other Unearned Income - Check the appropriate box to show if the case record indicates receipt of other unearned income by the members of the Medical Assistance Group during the review month.

(b) Resources

Real Property (Home and Other)- Check the appropriate box to show if the case record indicates that member(s) of the Medical Assistance Group has real property resources such as ownership of a "home" as defined by the State plan, during the review month.

Other Personal Property - Check the appropriate box to show if the case record indicates that member(s) of the Medical Assistance Group had other personal property such as a motor vehicle.

Life Insurance - Check the appropriate box to show if the case record indicates the existence of any medical insurance policy(ies) covering any member(s) of the Medical Assistance Group during the review month.

Medical Insurance - Check the appropriate box to show if the case record indicates the existence of any medical insurance policy(ies) covering any member of the Medical Assistance Group effective during the review month.

Liquid Assets - Check the appropriate box to show if the case record indicates ownership of liquid assets that are considered as resources under the State plan by any member(s) of the Medical Assistance Group during the review month. Include in this item bank deposits, cash on hand, and stocks or bonds.

III. Eligibility Field Review Information

N. Does the Field Review Show the Presence of any of the Following Elements During the Review Month?

Complete Item N for those elements listed under Item M, above. The findings documented should be taken from the field investigation (Column 3 of the worksheets).

IV. Eligibility Summary Findings

Section IV of the schedule provides for reporting the actual status of the case eligibility as of the review month. Any change subsequent or prior to the review month which might be found by the reviewer to have taken place is not to be indicated on this schedule. Section IV is to be completed immediately after the completion of field review activities.

O. Disposition of Review:

1. Review Completed - Check box 1 if the review was completed through a field investigation.

   Review Not Completed Due to - If for some reason a review of a case was not completed to a definitive conclusion, fill out as much of Section I of the Review Schedule as is possible, check the appropriate box as follows:

2. Moved Out of State Since Review Month - Check this item if the beneficiary has moved out of the State and the agency's jurisdiction since the review month but before the review could be undertaken or completed.

3. Unwilling to Give Information - Check this item if a definitive conclusion on eligibility cannot be reached because of the beneficiary's refusal to participate in the review process.

4. Unable to Locate - Check this item when a field investigation is not possible because the case members cannot be located.

5. Listed in Error - Check this item when the case was sampled in error.

6. Other - Check this item when the field investigation or the review cannot be completed for a reason other than those mentioned above. The reason for not reviewing must be indicated in the space provided.

If an item other than Item 1 is checked, no further entries are required on the remainder of the schedule.

P. Eligibility Coverage Requirement Used by Reviewer for Eligible Cases - For eligible, mixed eligibility, and ineligible AFDC-QC/SSI-QA cases found eligible during a MQC review or rereview, enter the code from the Verification Guide under which the MQC reviewer established eligibility. If more than one code may be appropriate, perhaps in a multi-member case, code 9 9 and explain in Section V of the Review Guide.

Q. Eligibility Review Findings - Indicate the appropriate findings based on case review activities. This information corresponds to the summary data contained in Section D of the facesheet of the MQC Eligibility Worksheets.

1.a. Case Status - Enter a check in the box to the left of the appropriate case eligibility finding and record the associated number in the case summary box. In this regard, the following prevails:

(1) Check this item if no case liability existed and all members of the case were eligible for the entire review month.

(2) Check this item if no case liability existed and each member of the case was ineligible for all or part of the review month.

(3) Check this item if no case liability existed and some members of the case were eligible for the entire review month and some members were ineligible for all or part of the review month.

(4) Check this item if case liability existed, error resulted in an understatement of liability, and all case members were eligible for the entire review month.

(5) Check this item if case liability existed, error resulted in an overstatement of liability, and all case members were eligible for the entire review month.

(6) Check this item if case liability existed, error resulted in an understatement of liability, and some case members were ineligible for all or part of the review month.

(7) Check this item if case liability existed, error resulted in an overstatement of liability, and some case members were ineligible for all or part of the review month.

1.b. Case Member Status - Enter the number of beneficiaries which fall in each category. A two digit number should always be entered, e.g., [0][1], [0][0].

2. Number of Elements in Error - Enter the total number of elements in error that were identified in the review. If case was eligible enter [0][0]. A two digit number should always be entered, e.g., [1][1], [0][3].

R. Overall Dollar Amount of Liability Error - The QC reviewer should enter the overall dollar amount of liability errors identified during the review. This amount corresponds to the amount indicated in item D. 3 of the facesheet of the MQC Eligibility Worksheets.

Since a review of a case liability may reveal more than one error, the dollar amount representing the net (algebraic) effect of the errors should be entered in Item R.

This dollar amount is developed by combining the actual dollar and cents of the errors which led to a finding of overstated or understated liability.

This net figure will then be rounded off to the nearest dollar. If the amount is 50 cents or more, the dollar amount is increased by one. If the amount is 49 cents or less, the dollar amount remains the same. For example, if the amount of liability error was $47.52, the reviewer should code [0|0|0|4|8]. If the amount of the liability error was $162.12, the reviewer should code [0|0|1|6|2].

Amounts of $5.00 or more before rounding are considered liability errors in MQC.

S. Does There Appear to be Willful Misrepresentation of Facts?

The reviewer will report in this item whether there is indication that the incorrect status of the case is due to willful misrepresentation by the beneficiary or his representative. Willful misrepresentation covers (1) false or improper information knowingly supplied, and (2) correct or required information knowingly withheld.

T. Description of Error(s) - This item identifies six characteristics of each error: element, nature of error (when not evident from element), type (agency or beneficiary), findings (eligibility or liability incorrect), number of case members with error, and date error occurred.

The codes to be used for element, nature, and type of error are listed following these instructions.

Characteristics of up to five errors are to be coded in Item T. If there are more than five errors, the five errors coded should be selected according to the following criteria.

First, all eligibility errors should be coded. If there are more than 5 eligibility errors, the eligibility errors should be selected based on the order in which they occur on the worksheets.

If there are less than 5 eligibility errors, the remaining errors coded will be liability errors. If there are more liability errors than space for recording the remaining errors, select the elements with the highest net dollar amount of error. If the net dollar amounts are equal, select the errors to be coded based on the order in which they occur on the worksheets.

No error should be coded in Item T if it does not reflect ineligibility or incorrect liability.

For each error, code Item T as follows:

1. Element - Elements are listed in five main groups called program areas. (Explanations of these elements are given in Subchap 3460 of the QC Manual).

   States may add additional elements (or sub-elements) and nature or type of error codes at their option. The numbering system will accommodate this expansion.

   Enter the appropriate three digit code from Subchap 3493 to indicate the element (or sub-element) in error.

   No more than one eligibility error per numbered element or sub-element may be coded.

2. Nature - Enter the appropriate two digit code from Subchap 3493 to indicate the nature of the error for the element in error. If the coded element is followed by an asterisk (*), enter 9 9 in the "Nature" columns.

3. Type - Enter the appropriate two digit code from Subchap 3493 for the type of agency or beneficiary error. If agency and beneficiary are both responsible for the eligibility error, enter only the agency type code.

   a. Agency Error - An agency error is defined as an error which occurs because of failure on the part of the Medicaid agency or designated State agency to discharge its responsibilities in a proper and timely manner directly resulting in ineligibility or incorrect determination of liability. These types of errors are listed on the following page.

- Correct Policy but Incorrectly Applied (Code 10) - Enter this code if the agency has incorrectly applied the correct State policy to the facts at hand which resulted in ineligibility or incorrect determination of liability.

- Wrong Policy Applied (Code 20) - Enter this code if the agency has failed to apply the proper State policy to the facts at hand.

- Reported Information Disregarded or not Applied (Code 30) - Enter this code if the agency failed to take action on information supplied by the beneficiary(ies) or by other sources.

- Failure to Follow-Up on Impending Changes (Code 40) - Enter this code if the agency failed to follow-up on known changes in the beneficiary's circumstances which resulted in incorrect eligibility status.

- Failure to Follow-Up on Inconsistent or Incomplete Information (Code 50) - Enter this code if in the reviewer's opinion the agency failed to follow-up on inconsistent or incomplete information supplied by the beneficiary(ies) when this should have been apparent or is available from sources to the agency.

- Failure to Verify Where Required by Agency Policy (Code 60) - Enter this code if the agency failed to verify the eligibility factor as required by State policy, e.g., complete redetermination.

- Arithmetic Computation (Code 70) - Enter this code when the agency has made an error in computation or transcription which resulted in incorrect eligibility or liability status.

I. STATE CODE (ITEM A)

Enter the two-digit State code from the following listing. These codes are the standard codes used by the National Bureau of Standards

State	Code
Alabama	01
Alaska	02
Arizona	04
Arkansas	05
California	06
Colorado	08
Connecticut	09
Delaware	10
Dist. of Columbia	11
Florida	12
Georgia	13
Hawaii	15
Idaho	16
Illinois	17
Indiana	18
Iowa	19
Kansas	20
Kentucky	21
Louisiana	22
Maine	23
Maryland	24
Massachusetts	25
Michigan	26
Minnesota	27
Mississippi	28
Missouri	29
Montana	30
Nebraska	31
Nevada	32
New Hampshire	33
New Jersey	34
New Mexico	35
New York	36
North Carolina	37
North Dakota	38
Ohio	39
Oklahoma	40
Oregon	41
Pennsylvania	42
Puerto Rico	72
Rhode Island	44
South Carolina	45
South Dakota	46
Tennessee	47
Texas	48
Utah	49
Vermont	50
Virginia	51
Virgin Islands	78
Washington	53
West Virginia	54
Wisconsin	55
Wyoming	56
Guam	66

II. ELEMENT CODES (ITEM T)

BASIC PROGRAM REQUIREMENTS (100)

Code	Element Description
110	Age
120	Citizenship/Alienage
130	Residency
140	Living Arrangement
151	Deprivation-Death
152	Deprivation-Incapacity
153	Deprivation-Continued Absence
154	Deprivation-Unemployed Father
160	Blindness/Disability Determination
170	Marital Status
180	Other Categorical Relationship Requirements

RESOURCES (200)

Code	Element Description
210	Real Property
221	Liquid Assets-Cash on Hand
222	Liquid Assets-Bank Accounts
223	Liquid Assets-Stocks and Bonds
224	Liquid Assets-Other
230	Life Insurance
240	Medical Insurance
250	Other Personal Property
260	Disposal of Property

INCOME (300)

Code	Element Description
310	Earned Income
320	RSDI Benefits
331	Other Government Program Benefits-Veterans Benefits
332	Other Government Program Benefits-Unemployment Compensation
333	Other Government Program Benefits-Workmen's Compensation
334	Other Government Program Benefits-SSI
335	Other Government Program Benefits-Other
340	Pensions or Other Benefits
350	Support Payments
360	Income, In-Kind or Deemed
370	Other Income

ELEMENT CODES (continued)

COMPUTATIONS OF FINANCIAL ELIGIBILITY (400)

Code	Element Description
410.....	Computations of Gross Income
420.....	Deductions/Countable Income
430.....	Arithmetic Computation
440.....	Beneficiary Liability Determination

OTHER MEDICAID COVERAGE REQUIREMENTS (500)

Code	Element Description
510.....	AFDC Related Budgetary Allowances
521.....	AFDC Special Needs-Child Care
522.....	AFDC Special Needs-Transportation
523.....	AFDC Special Needs-Work Expenses
524.....	AFDC Special Needs-Personal Care
525.....	AFDC Special Needs-Other
530.....	Grandfathered Coverage Provisions
540.....	Other State Medicaid Criteria

III. NATURE CODES (ITEM T)

Corresponding* Element Code	Nature Code	Explanation of Nature Code
110	01	Beneficiary or Child of Beneficiary Over Age Required for AFDC Categorical Relationship
	02	Beneficiary Under Age Required for SSI Categorical Relationship
140	03	AFDC Related-Not Living With Relative
	04	AFDC Related-Relationship Not Established
	05	SSI Related-In Household of Another
	06	Not in Institution
160	07	Not Blind During the Review Month
	08	Not Disabled During the Review Month
250	09	Motor Vehicle in Excess of State Value Limitation
	10	Other Personal Property in Excess of State Value Limitation
310	11	Employment Status Changed to Full Time
	12	Employment Status Remains the Same, but Earnings Change
	13	Employment Status Changed to Part Time
	14	Recipient Unemployed
320-350,370	15	Unearned Income Increased
	16	Unearned Income Decreased
360	17	In-Kind Income Increased
	18	In-Kind Income Decreased
	19	Deemed Income Increased
	20	Deemed Income Decreased
410	21	Gross Income Overcounted
	22	Gross Income Undercounted

* For elements not listed, the nature of error should be apparent from the type code or the Medicaid eligibility coverage requirement code. Code"99" for these elements.

NATURE CODES (continued)

Corresponding Element Code	Nature Code	Explanation of Nature Code
420	23	Too Many Disregards Applied
	24	Too Few Disregards Applied
	25	Disregard Applied Incorrectly
	26	Too Many Deductions Applied
	27	Too Few Deductions Applied
430	28	Incorrect Financial Eligibility Standard Utilized
	29	Income "CAP" for Institutionalized Cases not Applied
	30	Arithmetic Error
	31	Transcription Error
440	32	Medical Expenses Undercounted
	33	Medical Expenses Overcounted
	34	Allowable Maintenance Level Understated
	35	Allowable Maintenance Level Overstated
	36	Wrong Period for Spenddown Utilized
	37	Liability Not Met Prior to Certification
510	38	Shelter Allowance Incorrect
	39	Consolidated Standard Incorrect
	40	Proration in Shared Household Incorrect
	41	Other Allowance Incorrect
521-525	42	Special Needs Included, Not Required
	43	Special Needs Required, Not Included
	44	Incorrect Amount of Special Needs
530	45	Not Title II Beneficiary in August, 1972
	46	Not Institutionalized in December 1973
	47	Not Institutionalized Sometime Between December, 1973, and the review month
	48	Not Essential Spouse in December, 1973
	49	Not Essential Spouse Sometime Between December, 1973,and the review month
	50	Not Blind or Disabled in December, 1973
	51	Not Blind or Disabled Sometime Between December, 1973 and the review month
	52	Not SSI/SSP Cash Beneficiary at time of C.O.L. increase after April, 1977
540	80	No agency record Medicaid eligibility determination
	81	Liability has not been recomputed and spenddown period has expired
	82	Beneficiary died prior to the review month
	83	Redetermination not conducted as required by State plan

b. Beneficiary Error - A beneficiary error is defined as the error which occurs because of failure on the part of a beneficiary, guardian, or authorized representative to give correct information or otherwise discharge his responsibility in a proper and timely manner, directly resulting in ineligibility or incorrect determination of liability. These types of errors are classified as follows:

- Change in Circumstances not Reported (Code 01)- This code applies to errors in eligibility status due to unreported changes in the beneficiary's circumstances.

- Information is Incorrect (Code 02)- Enter this code whenever a beneficiary has provided incorrect information which results in ineligibility or incorrect determination of liability.

- Information is Incomplete (Code 03) - Enter this code whenever a beneficiary has provided incomplete information which results in ineligibility or incorrect determination of liability.

4. Error Finding - Enter the code which describes the effect of each individual error on case eligibility, assuming it was the only error identified in the review:

(1) Eligible
(2) Ineligible
(3) Eligible w/Ineligible Members
(4) Liability Understated Error Only
(5) Liability Overstated Error Only
(6) Liability Understated Error w/Ineligible Member(s)
(7) Liability Overstated Error w/Ineligible Member(s)

5. Number of Case Members with Error - Enter the number of case members for whom the reviewer has found an error of the same element, nature type, and error finding. For example, all members of a case could be ineligible based on the same error, e.g., element 153, deprivation-continued absence. The number of case members to whom each error is applicable is entered under this item.

6. Date Error Occurred - The month and year represent the date that an error first affected the element of eligibility finding. Where multiple errors affect an element error finding, the date that an individual error first occurred should be entered in Item T.

The entry should be the two digit numerical code for month and the last two digits of the year.

In no instances should a month and year be coded which occur after the review month.

V. Explanation of Eligibility Errors

Error codes in the Medicaid Quality Control System are intended to provide detailed information on the nature of the error directly affecting eligibility. In most instances, further explanation in this section should be unnecessary.

This section provides the opportunity for the QC reviewer to make entries which significantly contribute to the understanding of the nature and type of the error over and above that supplied by the code. Entries in this regard, therefore, should be made on an as needed basis.

Further, this section may be used, at State option, for reviewers to make recommendations as to what, in their opinion, should be done to prevent recurrence of the particular error being reported. The entries in this section, therefore, should be focused on providing useful information for consideration by the State agency in the corrective action planning process.

1. Elements - Enter in this column the code(s) of the program element that was checked on the worksheet as being in error. For example, if the worksheet showed the error was due to "Age" Code 110 would be entered.

2. Nature of Error(s) - Opposite the element identified in Column 1, the reviewer selectively will enter other pertinent information that explains the reason for the error which contributes to the understanding of the nature of the error beyond that provided by the error codes. Also, the individual reviewer's observation of why the error occurred and what should be done to prevent its recurrence may be entered here.

3. State Manual Citation - The reviewer may enter here the citation of the policy, i.e., manual section, paragraph, page number, etc., involved in the incorrect eligibility.

3493 MQC Review Schedule Codes

This section presents codes to be used by the QC reviewer while completing the Review Schedule. Codes for Items A and T on the Review Schedule are presented.

IV. TYPE CODES (ITEM T)

Agency Errors

Code

10.....Correct Policy but incorrectly applied

20.....Wrong policy applied

30.....Reported information disregarded or not applied

31.....Reported information inaccurate

40.....Failure to follow-up on impending changes

50.....Failure to follow-up on inconsistent or incomplete information

60.....Failure to verify where required by agency policy

70.....Arithmetic computation

Beneficiary Errors

01.....Changes in circumstances not reported

02.....Information provided is incorrect

03.....Information provided is incomplete

3500 THIRD PARTY LIABILITY REVIEW

3510 INTRODUCTION AND PURPOSE

Medicaid is experiencing spiraling service costs which are compounded by misspent dollars. These misspent funds result from errors in eligibility determinations and erroneous payments. Recovery of third party liability resources presents an important opportunity for reduction of Medicaid program costs. For the purpose of MQC review, third party liability (TPL) may be defined as: "Those payment resources available from both private and public health insurance, and from other liable third parties, that can be applied toward Medicaid beneficiaries' medical and health benefit expenses."

3511 Purpose of TPL Review

The purpose of third party liability review is to assess the effectiveness of Medicaid program administration as it relates to third party recovery. The review is to supply the following four findings:

1. Were third party resources available to the beneficiary during the review month?
2. If third party resources were available, was that fact known to the State Title XIX agency?
3. If third party resources were available, were they fully utilized?
4. If available and not fully utilized, how much was inappropriately paid by Medicaid?

The recovery process for known or discovered resources that cover medical expenses of medical assistance beneficiaries will be given in the State plan or other State policies. The TPL review collects information with which the State may measure its performance in the utilization of TPL resources. The resultant findings can be a basis for corrective action planning.

3512 Legislative and Regulatory Authority for TPL Review

The authority for third party liability review and recovery is found in Sections 1902 (a) (17) (B) (C), 1902 (a) (18) and 1902 (a)(25), Title XIX of the Social Security Act and in 42 Code of

Federal Regulations 450.31, 449.40, 449.41 and 449.70. The primary regulation for third party recovery is stated as follows:

"42 CFR 450.31 "PAYMENTS FOR MEDICAL SERVICES AND CARE BY A THIRD PARTY"

(a) Requirements for State Plans. A State plan for medical assistance under Title XIX, Social Security Act, must provide that:

(1) The State or local agency will take reasonable measures to ascertain any legal liability of third parties arising after March 31, 1968, for the medical care and services included under the plan, the need for which arises out of injury, disease, or disability of applicants for or recipients of medical assistance.

(2) The State or local agency in determining whether medical assistance is payable, will treat any third party liability as a current resource when such liability is found to exist and payment by the third party has been made or will be made within a reasonable time.

(3) The State or local agency will not withhold payment in behalf of an eligible individual because of the liability of a third party when such liability of the amount thereof cannot be currently established or is not currently available to pay the individual's medical expense.

(4) The State or local agency will seek reimbursement from a third party for assistance provided when the party's liability is established after assistance is granted and in any other case in which the liability of a third party existed, but was not treated as a current resource."

Title XIX is clear in its intent that funds of the medical assistance program be expended only after all other available resources; in effect, Medicaid is the last payor.

3520 THIRD PARTY RESOURCES

For purposes of Medicaid Quality Control review, third party resources can be categorized into four major types, as follows:

1. Health Insurance
2. Government Programs
3. Liability/Casualty Insurance
4. Other Third Party Resources

Each of these is discussed below. Reviewer understanding of these various types of third party liability is essential to the effective conduct of TPL QC review. Further description of various TPL resources is found in the MQC training materials.

3521 Health Insurance

Private health insurance includes individual and group contracts and commercial hospital and medical-surgical policies. Coverage may vary from limited, fixed liability with low dollar and duration limits to comprehensive service benefits. In some States, a substantial percentage of Medicaid beneficiaries have residual coverage from previous employment or continue to pay for insurance coverage out of their cash assistance grants. Medicare beneficiaries frequently hold relatively low-cost insurance policies which supplement their Medicare coverage. Health Maintenance Organizations (HMOs) combine the ideas of personal and group insurance, as the individual pays a regular fee at specified intervals, usually monthly, in a form of prepaid medical care. HMO premiums or other capitation payment arrangements and services provided under these arrangements will not be included in the MQC TPL review. Services received by HMO members from other providers are to be included in the TPL QC review. Frequently in AFDC related cases, an absent parent will carry personal or group insurance that covers his dependents' medical expenses.

The QC reviewer should be aware that income maintenance insurance policies may be available in instances of illness or disability. These policies are not included in the MQC TPL review of Medicaid beneficiaries.

Although different carriers offer similar types of health insurance, the variations in policies and coverages are extreme. However, private health insurance policies (sometimes referred to as "hospitalization or medical expense policies" by the layman) generally fall into two broad categories: Basic Coverages policies and Major Medical policies.

Under a Basic Coverages policy, benefits for hospitalization begin with the first day of confinement, and surgical benefits begin with the first dollar of surgical fees incurred. Usually, these Basic Coverages are not subject to a deductible, or have a very small deductible. Limitations are usually imposed on each element of medical expense. Examples of expenses covered by the Basic Coverages policy are hospital confinement, surgery and doctors' inpatient visits to the hospital. The medical provider, who has received an assignment of benefits from the insured, usually bills the insurance carrier for direct reimbursement of covered expenses, with the insured remaining liable for any non-covered expenses.

The Major Medical policy does not cover the first dollar of medical expense. Its purpose is to protect against the infrequent but financially burdensome loss that occurs when sickness or injury requires hospitalization or expensive surgical or medical treatment. This is accomplished through a "deductible" in order to eliminate small losses for which most families can budget and through a "co-insurance" requirement whereby the insured remains liable for some percentage of the incurred medical expense.

Examples of expenses covered by Major Medical are treatments or injections in a doctor's office, pharmacy, x-rays and laboratory expenses. The average family accumulates these expenses until the accumulation meets the annual family deductible. Thereafter, all such expenses are paid by the family, then submitted to the insurance carrier for reimbursement, less the family's co-insurance obligation which is usually 20% of the expense. Many of these policies require that expenses be accumulated over a 12-month period before the insured seeks reimbursement.

The reviewer will observe that most "group" insurance policies are "comprehensive" medical expense policies, combining both the Basic Coverages and Major Medical into one policy. The combination of these, however, does not alter their respective differences, nor the nature of their benefits.

3522 Government Programs

In the past two decades the Government has expanded its role in financing health care through programs such as Medicare, Veteran's Benefits, CHAMPUS and Medicaid. Medicaid, a public assistance program, is based on the concept of proven need. The others are "social insurance" programs because they are systems in which the elements of the insurance technique are present. The QC process addresses the underlying legal principle that benefits of these other Government programs must be availed prior to using Medicaid funds. A discussion of the Government programs to be included in the TPL QC review is given below.

3522.1 Medicare

Medicare is a system of Government-supplemented health care insurance for the aged and the totally disabled including blind persons meeting the definitions of disability. It was enacted by Congress in 1965 as Title XVIII of the Social Security Act.

Medicare has two parts. Part A hospital insurance helps pay the expense of a patient in a hospital, in a skilled nursing (extended care) facility, or at home

receiving services from a home health agency. Part B medical insurance helps pay for a doctor's services, outpatient hospital services, medical services and supplies, home health services, outpatient physical therapy, and other health care services. Medicare benefits are restricted to "covered services" in order to maximize the medical benefits that can be obtained with limited funds.

The Part A hospital insurance program is financed by contributions collected with regular Social Security taxes on wages and self-employment income earned during a persons' working years. In some cases, Medicaid beneficiaries who have not established their eligibility for Social Security during their working lives pay a premium to obtain the hospital insurance. Most people age 65 or older should be eligible to enroll for Part A hospital insurance free of charge. The beneficiary who decides to enroll in Part B medical insurance pays a monthly premium for half the cost of his insurance, and the Federal government matches this payment to cover the balance of the cost. Part B medical insurance premiums can be automatically deducted from monthly checks for those who receive Social Security benefits, railroad retirement benefits, or a federal civil service annuity or can be paid directly to the Social Security Administration by the beneficiary or by a State assistance program. The beneficiary pays a yearly deductible amount, plus 20% of the cost of services covered under Part B medical insurance, with the Federal government paying 80%.

The use of hospital insurance under Medicare is limited according to maximum benefits allowed during "benefit periods". A benefit period starts with the first day a client enters an enrolled facility or receives a home health visit and ends after the client has spent 60 consecutive days without being an inpatient or receiving a home health visit. With limitations, Part A hospital insurance helps pay for up to 90 hospital days, up to 100 extended care days, and up to 100 home health visits during each benefit period. To help the client keep track of his benefit periods, the Social Security Administration sends him a notice of the number of days and visits he has left each time he uses his hospital insurance.

A client pays a monthly premium (or the State pays it for him) for Part B medical insurance. During a calendar year the client is then responsible for the first $60 charge on covered services (the deductible) and 20% of the rest of reasonable charges (the co-insurance).

Medicare pays the other 80% of reasonable charges. For radiology and pathology services for hospital inpatients and for home health services and diagnostic laboratory services billed directly only, Medicare Part B medical insurance will pay only up to a certain maximum amount (the reasonable charge).

The following clients will usually be eligible for Medicare Part A hospital insurance.

1. An individual age 65 or older who meets at least one of the following requirements:

   a. Has established eligibility for Social Security benefits (even if he does not actually receive these benefits);

   b. Is a qualified railroad retirement beneficiary;

   c. Attained the age of 65 before 1968;

   d. Attained age 65 after 1967 and has not less than three Social Security or railroad quarters of coverage, whenever acquired, for each year elapsing after 1966 and before the year in which he reached age 65. (This is a transitory provision which will not be applicable for women reaching age 65 in 1974 or for men reaching age 65 in 1975 or later.)

   e. Has enrolled for voluntary coverage and paid the monthly premium. In order to enroll for voluntary coverage, a person must be:

      (1) Ineligible for regular free coverage under existing law;

      (2) Enrolled for Part B medical insurance under Medicare;

      (3) Residing in the United States;

      (4) Either a citizen or an alien lawfully admitted for permanent residence who has lived here for at least five years.

2. An individual of any age who meets at least one of the following requirements:

   a. Has been entitled for at least 23 consecutive months to cash benefits under Social Security and railroad retirement programs because he is disabled, including:

      (1) Disabled workers at any age;

      (2) Disabled widows;

      (3) Disabled dependent widowers between the ages of 50 and 65;

      (4) Women age 50 or older entitled to mother's benefits who, for 24 months prior to the first month they would have been entitled to Medicare protection, met all the requirements for disability benefits except for actual filing of a disability claim;

      (5) People aged 18 and over who receive Social Security benefits because they become disabled before reaching age 22;

      (6) Disabled railroad retirement annuitants.

   b. Requires hemodialysis or renal transplantation for chronic renal disease, if currently insured by or entitled to Social Security benefits, or the spouse of dependent of such an individual. (Eligibility becomes effective in the third month following the month in which renal dialysis is initiated and continues through the 12th month after its completion.)

An individual who has paid the premium and meets at least one of the following conditions is eligible for Medicare Part B medical insurance:

1. Is age 65 or older, a resident of the United States, and either a citizen of the United States or an alien lawfully admitted for permanent residence who has resided in the United States continuously during the five years immediately before the month he applies for enrollment.

2. Is entitled to Part A benefits (including severely disabled persons or persons with chronic renal disease as specified).

Before conducting TPL reviews of cases in which Medicare represents the third party resource, the reviewer should thoroughly familiarize himself/herself with Medicare policy on: the specific services covered and service limitations under Parts A and B; co-insurance requirements and co-payment requirements for each covered service. This information is summarized in the TPL training materials developed for the MQC system and is given in detail in Federal regulations.

3522.2 CHAMPUS

CHAMPUS (Civilian Health and Medical Program of the Uniformed Services) is a health care benefit resource generally available to dependents, children, and spouses, of all uniformed military service personnel. It is also available to retired military service personnel and dependents of retired or deceased retired personnel.

Covered benefits under the CHAMPUS program include: inpatient hospital care, outpatient medical care, surgery, treatment for nervous and mental conditions and contagious diseases. Coverage also may include medical supplies, drugs, insulin, ambulance, family planning, some dental care and rental of equipment such as wheelchairs, hospital beds, etc.

CHAMPUS also includes a program of benefits for handicapped dependents which provides for diagnosis, inpatient and outpatient care, home care, and institutional care.

3522.3 Veteran's Benefits

Under Veterans Administration programs, medical and dental benefits may be available to any veteran who has been honorably discharged from the armed services. These benefits are most available to those with service connected disabilities. Preference is given to veterans over age 65 or to those who have received the Medal of Honor. Spouses and dependents of veterans may be eligible for benefits under some circumstances.

Benefits potentially available to those with service connected disabilities include: hospital care, dental care, prosthetic appliances, special equipment, dogs and mechanical aids for the blind, domiciliary care. Other benefits available on a limited basis to all veterans are: drug dependence treatment, hospital care, dental care, and domiciliary care.

3523 Liability/Casualty Insurance

Medicaid beneficiaries may require medical services because they have been injured in an accident, through work or through the negligence of others. These injuries may result in others being liable for the payment of the associated medical expenses. Third party resources may include liability insurance coverage carried by the responsible party and auxiliary coverage, often found to be a part of the casualty policy, but different from the liability coverage.

In the QC process the reviewer will have to develop a firm understanding of the nature of liability coverage. The word "liable" means "responsible". The liability that the insurance policy covers is the responsibility of the insured to pay for the damages of another person. This liability arises from the negligent act or acts of omission of the insured.

Whether the insured is legally responsible for the injury sustained by another person can only be determined by a court of law. More frequently than not, however, insurance companies settle the majority of claims against the liability coverage without final adjudication by a court. In either case, claims adjudication requires much time--sometimes years. The time constraints of the QC process will not allow delay of the review until final adjudication. Therefore, if adjudication is not complete at the time of the QC review, TPL errors cannot be measured in "dollar" loss.

Auxiliary coverage under casualty insurance includes "Medical Payments coverage" under which the insurance carrier agrees to pay the medical expenses of persons who have been injured in certain circumstances, but only up to a limited amount stated in the policy. Usually, the amount is limited to $500 per person, but it can be considerably more. The liability of the insured is never a question in this instance, i.e., the insurance carrier is not concerned with whether the injury was the fault of their insured under this coverage. It is important to remember that if the injury occurred in the required circumstances, the carrier will pay the medical expenses up to the policy limit, irrespective of liability.

The primary purpose of auxillary coverage is to cover the moral obligation that the insured may feel toward anyone who has been injured on his premises or in connection with the activities of the insured.

The required circumstances under which the carrier will pay the medical expenses are as follows:

1. The injury must be accidental; it can not have been caused intentionally;

2. If the accident happened on the insured's premises, the injured person had to have been there with the insured's permission. The permission does not necessarily have to be explicit. It can be an implied permission; e.g., a postman coming on the premises to deliver mail;

3. If the accident happened away from tne insured's premises, one of the following must have occurred:

   a. The accident must have arisen from some condition of the premises or the ways immediately adjoining the premises; e.g. a brick falls off a chimney and strikes a passerby on the sidewalk below.

   b. It must have been caused by the activities of the insured;

   c. It must have been caused by an employee of the insured who is acting in the course of his employment;

   d. It must have been caused by an animal owned by or in the care of the insured; e.g., watch dog on business premises or family pet.

In all of the above circumstances, the carrier will pay for surgical, dental, hospital, X-ray, ambulance, medications, professional nursing and any other medical expenses related to the accident, but only for those incurred within one year from the date of the accident, providing they are reasonable and necessary. These expenses will be paid only up to the limits of the medical coverage amount stated in the policy. The coverage will not pay for medical expenses of the insured nor employees of the insured.

A Quality Control review of a casualty situation should always include an inquiry into the availability of medical payments coverage, either through an examination of the policy or communications with the insurance carrer.

In the next several paragraphs, various casualty insurance policies are described. These include policies available for:

Homeowners; Owners, Landlords and Tenants; Products Liability; Malpractice; Worker's Compensation; and Automobile.

3523.1 Homeowner's Insurance

Personal liability and medical payments coverages are always a part of any Homeowner's insurance policy. They are separate and distinct. As noted above, personal liability coverage payments are made for medical expenses only if the insured is liable. Medical payments coverage under a Homeowner's policy generally extends payment for those services noted under the general description of this type of coverage.

To determine what is covered under Homeowner's personal liability coverage, one must look to the standard insuring clause which reads as follows:

> The company agrees:
>
> To pay on behalf of the insured all sums which the insured shall become legally obligated to pay as damages because of bodily injury or property damage and the company shall defend any suit against the insured alledging such bodily injury or property damage and seeking damages which are payable under the terms of this policy, even if any of the allegations of the suit are groundless, false or fraudulent; but the company may make such investigation and settlement of any claim or suit it deems expedient.

The standard clause clearly states that there must be some substantial degree of liability exposure on the part of the insured before the insurance carrier will consider a payment for personal injury. This liability exposure arises when the injury was:

1. Caused by an unintentional act; i.e., accidental;
2. Arose out of a condition of the premises;
3. Arose out of a condition of the ways adjoining the premises;
4. Perpetrated by the insured;
5. Perpetrated by an insured's residence employee;
6. Caused by an animal owned by or in the care of an insured.

An important factor in the Homeowner's personal liability coverage is that, unlike most insurance policies which cover only those persons named in the policy as "the insured", "the insured" means not only the person named in the Declarations section of the policy, but also that person's spouse and any relatives of either who are permanent residents of the household. It also includes as "the insured" anyone under 21 living permanently with and in the care of the insured.

3523.2 Owners, Landlords and Tenants Insurance

Department stores, apartment buildings, office buildings, bowling alleys, theaters, and other buildings not used for manufacturing almost always carry Owners, Landlords and Tenants (O.L.&T.) insurance. Often injuries sustained on these premises are not restricted to the slip-and-fall category, but involve serious injuries with costly medical expenses.

Not unlike Homeowner's insurance, these policies usually provide two coverages: Liability coverage and Medical Payments coverage.

The O.L.&T. policy covers the insured's liability arising from the ownership, maintenance, or use of premises occupied by him. It will cover his liability for damage to those who sustain injury in and about the premises. It also protects the insured against claims for injuries sustained off the premises when the injury arises from the operation of the insured's business. An example would be an injury sustained by a customer when the delivery man delivering a sofa or chair accidently drops it on the customer's foot.

Medical Payments coverage is usually a coverage offered with O.L.&T. policy, in addition to the liability coverage. As previously discussed under the medical payments coverage section of this text, liability of the insured does not play a role in the availability of medical payments coverage. Under this coverage the injured person is paid medical benefits regardless of whether the insured was at fault. As in other policies, there are limitations to this coverage. The claims are limited to expenses incurred within one year from the date of the accident and up to the limits of the medical payments coverage.

3523.3 Products Liability Insurance

An additional area of business liability involves the manufacture and consumption of products. Examples of

products that may and do cause injuries are food, drugs, toys, furnaces, appliances, inflammable clothing--all forms of cosmetics, soaps and other similar products. Thousands of claims against vendors and manufacturers of these products are presented annually. As a result of the high volume of claims presented against these businesses, all but a few carry adequate products liability insurance.

In the QC process the reviewer should inquire about the cause of any traumatic illness or injury, because it is possible that a beneficiary has filed a product's liability claim for which there is insurance to cover the person or company who caused it.

In order for these types of claims to be compensable, it must be established that there is liability. However, establishing liability in products liability cases may not present much difficulty. For example, a retailer who does nothing but sell a product can still be sued. Frequently, the courts have held that when you sell something, you warrant that the product is fit for use. This has been upheld even though the product is sealed in a box, bottle or can and the storekeeper has no way of knowing it is defective. He can be sued on breach of warranty. Thus, while only a limited number of cases of this type may be found during the QC process, the reviewer should recognize that liability may be more likely to have been established in these cases, thus permitting estimates of TPL dollar errors.

3523.4 Malpractice Insurance

Malpractice policies are usually carried by doctors, surgeons, dentists, medical technicians, hospitals, clinics, nursing homes and other establishments rendering medical care. Malpractice lawsuits are filed to recover damages for injuries sustained due to alleged negligence by the insured or by any employee for whose actions he is legally responsible; e.g., a nurse, radiology technician, etc. Examples of these are: a claim for injury because a doctor stopped treating a patient before the patient was cured; a claim for injuries because of faulty diagnosis or treatment.

Other examples of malpractice in connection with hospital or nursing home confinement are:

1. Patients scalded in hot baths due to negligence of employees;

2. Injuries to patients resulting from falls from bed due to negligence of employees;

3. Failure to recognize or treat a worsened condition which results in death or injury of patient;

4. Injuries to patients resulting from falls out of wheelchairs due to negligence of employees;

5. Injury or death of patient resulting from improper medication or improper dosage being administered by doctor or nurse;

6. Failure to place patients in restraints where history indicates restraints are required and unrestrained patient injured another.

These types of claims are distinguished from those arising from the premises of a hospital or nursing home; e.g., patients or visitors falling in the wards, corridors, etc., due to a condition in the premises. The latter types of claims are covered in an Owner, Landlord & Tenant policy or some other type of general liability policy. Medical providers usually assure that all accidents occurring in their facilities are covered by insurance.

Malpractice insurance policies provide coverage for payment of medical bills only if liability exposure exists on the part of the insured. Medical Payments coverage, which does not concern itself with the liability of the insured, is not a part of the malpractice insurance policy.

3523.5 Workmen's Compensation

Workmen's Compensation laws are in effect in every State. They operate to mitigate the losses sustained by persons injured on their jobs. Basic provisions in all such laws require compensation for lost income and medical expenses resulting from diseases or injuries experienced through employment. The worker's indemnity is usually 66-2/3% of his average weekly wage. The TPL QC process is concerned only with compensation for medical expenses. However, reimbursement for lost income, especially in

a lump sum settlement, can affect a person's eligibility for medical assistance. Lump sum settlements may be made at the worker's option when the injury results in loss of sight, hearing, limbs or other permanent disabilities.

State laws vary in their treatment of compensation for medical expenses. Some pay all necessary expenses while others limit the amount of liability for medical expenses.

Usually, employers buy insurance that will pay the sums for which they may become liable under Workmen's Compensation laws. Some State laws require that insurance be purchased from a State insurer called the "Workmen's Compensation Fund". Other States require the employer to buy his insurance from a private carrier. In many States the employer has the option to purchase from either. Additionally, most States permit "qualified" employers to be self-insured.

Despite each having its own particular system of compensation, there are many similarities among the plans. One such similarity is that agricultural workers and domestic workers are usually excluded under most plans. Frequently, public employees and employees of non-profit organizations are also exempted. Many States also exempt employers based on the number of employees. In those instances where employees are not covered by Workmen's Compensation laws, the injured or ill employee can bring a lawsuit against the employer wherein the employee would have to establish liability on the part of the employer.

Most Workmen's Compensation Acts have the folowing features:

1. Negligence by the employee or lack of negligence on the part of the employer does not affect the employees rights to benefits, whenever he sustains an injury arising out of, or in the course of, employment

2. No compensation shall be payable if the injury was occasioned solely by the intoxication of the employee or by the wilful intention of the employee to injure himself or another person.

3. Benefits for the employee include medical expenses and weekly indemnity to compensate for the loss of wages.

4. The employee:

   (1) May elect to sue the third party whose negligence caused the injury and waive his workmen's compensation benefits or

   (2) May elect to collect compensation benefits and assign subrogation rights to the insurance carrier involved.

5. Workmen's Compensation benefits are the exclusive remedy for employees injured during the course of their employment. Employees may not sue the employer.

6. Compensable claims are not limited to industrial injuries, but also include industrial disease.

It is essential that the QC reviewer become familiar with the benefits available under Workmen's Compensation Act of his/her State. Literature is available through local Workmen's Compensation Boards.

3523.6 Automobile Insurance

There are two operating systems in the automobile insurance field: "Tort Liability" (Fault) system and the "No-Fault" system. However, some States employ a hybrid Fault-No-Fault system. This combines the advantage of immediate compensation from the victim's own insurance carrier, while permitting the victim, or his estate, to commence a lawsuit because of a more serious injury, such as disfigurement, permanent disability or death. The two basic systems, tort liability and no-fault are discussed below. The QC reviewer should become familiar with the particular system which is operational in his/her State

The Tort Liability System is the traditional fault system which requires that the insured be liable before payments for medical or other expenses are made under this coverage; i.e., at fault or legally responsible for the injuries sustained by the victim.

A tort is a civil wrong recognized by the law and for which the law is willing to require the wrong doer to compensate the victim for his losses. The problem in the MQC process arising out of the Tort system is the uncertainty of the wrong doer's liability, or the extent to

which that liability exposure is sufficient to compensate the victim for his medical losses, and the delays arising from the insurance carrier's efforts to determine the extent of their insured's liability, or how much they will compensate the victim. Frequently, the insurance carrier is unable to make this determination to the satisfaction of the victim. This leads to drawn-out litigation and/or settlement negotiations.

If the QC review takes place while such action is pending, it is not possible to measure the "dollar" loss of any errors connected to a claim presented under the liability coverage. Only adjudicated claims will be measured in "dollar" loss.

Medical Payments coverage, previously discussed with other casualty policies, is also usually an auxillary coverage to the Liability coverage of an automobile policy, but a separate premium is charged for it. Unlike the Liability coverage, however, medical payments coverage by an insurance carrier does not require the insured to be at fault.

Medical Payments policies cover payment for surgical, dental, hospital, X-rays, medications, ambulance service, professional nursing and other "necessary and reasonable" medical expenses related to the accident. Medical Payments coverage will usually pay only those expenses incurred within one year from the date of the accident, up to the limits of the coverage as stated in the policy.

The "Stacking of Policies" concept is relevant in connection with this type of coverage. Simply stated, most insurance laws permit an injured victim to take advantage of all automobile insurance policies available to cover medical costs. Frequently, to cover medical costs the victim may utilize Medical Payments coverage in the respective order of the following policies.

1. Owner of auto in which victim was a passenger;

2. Driver of auto in which victim was a passenger (if he/she is not the owner of the auto driven but has medical coverage on his/her own auto, that coverage can be used by the victim);

3. Victim's own family auto.

4. Automobiles owned by relatives who permanently reside with the victim.

If the victim's cumulative medical expenses incurred within one year from the date of the accident are sufficiently high, he can avail himself/herself of the Medical Payments coverage afforded under each of the above policies.

In 16 States, No-Fault automobile insurance has replaced the Tort Liability system of compensating automobile accident victims for injuries. The victim now presents a claim to his/her insurance carrier, irrespective of who was at fault. As the system's name implies, the concept of "fault" is completely removed.

Most No-Fault laws are very liberal in providing for payment of "necessary and reasonable" medical expenses. While most States place a limit (usually very adequate) on the amounts available for medical expenses, some States' No-Fault laws may be written to provide unlimited coverage for medical expenses. The QC reviewer should become familiar with the specific provisions of his/her State's law.

The QC reviewer should also examine the order of priority in the No-Fault law which outlines which insurance policies take precedence. The situation could exist where the victim himself does not have insurance, but insurance would be available through the victim's relatives residing in his household.

Also, there are other possibilities wherein insurance is afforded. Some State laws require public carriers, such as buses and taxis, to provide No-Fault insurance for their passengers. That insurance would take precedence even if the passenger-victim had available his own No-Fault insurance.

Like the Medical Payments coverage, third party liability that is found in the QC process to relate to claims which are presented under No-Fault insurance are usually measurable in "dollars".

An additional type of insurance for medical expenses associated with automobile accidents is provided in some States through State Uninsured Motorist Laws. This may be applicable, for example, if a Medicaid beneficiary is the victim of an auto accident caused by an uninsured motorist. Such claims are compensable through the provisions of these laws, however, liability of the uninsured motorist must be established.

3524 Other Third Party Resources

There are resources available which do not fit in the category of health or casualty insurance or government programs, but do involve third party liability. These resources exist under State or Federal laws which provide for benefits that should be exhausted either prior to using Medicaid or as a form of reimbursement to the Medicaid Program. Some of these are discussed below.

When an illegitimate child is a part of the eligible group, it is possible to establish the legal identity of the father and recover confinement expenses where State laws provide for this as a support obligation. Confinement expenses include all medical costs incurred as a result of prenatal care, delivery, postnatal care, and all expenses incurred by the newborn until he leaves the hospital following his birth.

In many States upon establishing paternity, a court order is issued defining the exact amount of the damages (confinement expenses) to be repaid. In some instances if the natural father voluntarily consents to establishing his paternity, an acknowledgement to this effect may be signed and may include an agreement to be responsible for confinement expenses. In either case, a recovery resource exists.

When eligibility exists for dependent children or a disabled person and a spouse or parent is absent, a medical support obligation may exist on the part of the absent family member.

This circumstance most often exists in the case of separation (estrangement) or divorce. If a separation or divorce has occurred, generally some court or administrative order for support has been issued. This order may contain a specific requirement that the absent parent or spouse maintain health insurance on his dependents and/or be responsible for all or a portion of their medical expenditures.

It is also possible that an absent parent or spouse may maintain health insurance coverage for his dependents or provide medical support in the absence of a court or administrative order requiring him to do so.

In either case, a third party resource may exist.

An additional area of potential third party recovery is through probate of a deceased Medicaid beneficiary's estate. Title XIX regulation provides for a State to seek reimbursement, through probate action, from the estate of a deceased beneficiary for Medicaid payments for services rendered after the

beneficiary's 65th birthday. This should be done providing the beneficiary has none of the following survivors:

1. Spouse;

2. Child under 21;

3. Child of any age who is blind or totally and permanently disabled.

While probate may result in a substantial amount of Medicaid recoveries because these estates frequently have assets consisting of valuable real property, this area should be excluded from TPL QC reviews.

3530 THIRD PARTY LIABILITY QC POLICY

This section of the Manual presents the review policies to be following during TPL QC review. The section defines TPL errors and policies for reporting of errors and presents acceptable methods of coordination with insurance carriers and Federal agencies.

3531 Definition of a Third Party Liability Error

A third party liability error exists only when all of the following conditions are met:

1. There is conclusive evidence, established by the QC reviewer, that a third party was obligated to pay for services received by a beneficiary during the review month;

2. Medicaid paid for the services for which a third party was liable;

3. Medicaid did not recover or seek to recover the available third party funds within 30 days after the end of the month during which the claim was paid.

Each of these conditions is discussed below:

3531.1 Evidence of a Third Party Resource

It is critical to the integrity of the TPL review process that the QC reviewer demonstrate and document the obligation of a third party to pay for medical expenses incurred by a Medicaid beneficiary during the review month. For example, it is not sufficient to demonstrate that a Medicaid beneficiary had other health insurance coverage during the review month. Conclusive evidence that the available insurance would have covered the specific service for

which Medicaid paid is required. In addition, the reviewer must determine what portion of the amount paid by Medicaid would have been paid by the third party. This latter aspect, i.e., dollars in error, is to be discussed in subchap 3532.

Evidence of third party liability must be documented by the QC reviewer. This documentation requirement may involve a signed statement from a representative of an insurance carrier specifying that a third party was, in fact, liable for a Medicaid beneficiary's medical expenses and stating the amount of that liability. In another case, where an absent parent is under court order to provide medical insurance benefits for the specified dependents, the QC reviewer may be able to verify with the absent parent's employer that:

1. A beneficiary in the case under review is covered under the employer's group policy;

2. The specific review month service is covered;

3. Maximum dollar amount available for covered reviewed month services.

In this case a signed statement of the above from the employer would be desirable documentation.

As discussed in subchap 3520, conclusive evidence of third party liability will be most difficult to obtain in casualty related situations. Specific methods for determining third party liability in these situations are discussed in subchap 3553.

3531.2 Medicaid Payment for Services

The second condition that must be met in a TPL error situation is the occurrence of a loss to the Medicaid program, that is, Medicaid must have paid for services covered by a third party. Thus, for sampled cases where TPL is present but no services were received during the review month, no error can be present.

3531.3 Evidence of State Action to Recover

Because Medicaid agencies are required (both by law and to maintain provider satisfaction) to pay claims within reasonable time periods, it will not always be possible for the agency to delay payment of a claim until third party liability issues are resolved. The third condition of a TPL error situation recognizes the fact in that no TPL error can occur until 30 days after the end of the month

in which the claim was paid. This condition is similar to the "administrative period" in eligibility QC review which allows a State a specified period for changes in conditions affecting eligibility status to be documented.

Before a TPL error can exist, the QC reviewer must establish that the Medicaid agency did not review or take action to recover third party funds within the specified time period. Generally, the reviewer will need to examine the available files and records of the State unit responsible for third party recovery. Additional sources of verification will be insurance carriers, courts, other State agencies (e.g., the Office of Child Support Enforcement) and lawyers who represent Medicaid beneficiaries involved in Tort actions. This phase of the review process is presented in subchap 3560.

The QC reviewer will generally accept the following as evidence that a State has recovered or sought to recover third party funds.

1. Correspondence from the State to a third party that:

   a. Notifies the carrier of a loss;

   b. Requests information that is required for submitting a claim;

2. Correspondence from the State to the beneficiary requesting information on the specific third party resource or casualty situation that the QC reviewer has identified in relation to medical services during the review month;

3. Correspondence from a third party to a State that acknowledges the State's efforts to recover a claim for services during the review month;

4. Correspondence from the State to a lawyer or other individual representing a beneficiary (or vice versa) in a Tort situation that indicates the State's intent to seek recovery of third party funds for services during the review month;

5. A record indicating that payment of the specific TPL covered claim(s) under QC review has been obtained from a third party.

6. A record that a claim has been filed with a third party to recover funds for review month services;

7. Other records in State files indicating that appropriate State action has been taken to recover monies from a third party.

A Medicaid agency may enter into a contractual arrangement with another agency for recovery purposes. In these cases, the QC reviewer must establish that the agency under contract has sought to recover Medicaid funds for which a third party was liable. In some States, third party recovery may involve automated procedures between the State and third parties. The QC reviewer should request documentation for automated transactions where these are encountered.

It is evident from the items noted above that the QC reviewer will have to exercise some judgement in determining whether a State has sought to recover third party funds. The reviewer should become familiar with the third party recovery processes in his/her State, both for health insurance and for casualty situations, so he/she can identify what records or activities in the State indicate that recovery of a paid claim is being sought. However, the reviewer cannot modify the essential nature or scope of the TPL review to accomodate State recovery processes. For example, if a State TPL recovery unit expects providers to bill third parties in cases where other health insurance is available and does not seek recovery when the provider does not bill the third party, the reviewer cannot exclude these cases from review or fail to record an error if appropriate action to recover has not been taken.

3532 Dollar Amounts of TPL Errors

There are two considerations in associating a dollar value with a TPL error. The first is whether the specific dollar amount of third party liability is measurable. The second consideration is the dollar amount to be assigned to a TPL error. These considerations are discussed below.

If the amount of third party liability cannot be established reliably, there is no TPL error (subchapter 3550). For example, if liability has not been established and/or a claim adjudicated in a beneficiary's lawsuit against a homeowner whose dog bit him (and there is no Medical Payments coverage available), the reviewer should not try to estimate the dollar amount that might be settled on the beneficiary's claim. If, however, the claim has been adjudicated and Medicaid has not sought to recover, the QC reviewer should be able to estimate the available third party liability. In some of these cases, the reviewer will be able to assume that all of Medicaid's review

month payments related to the beneficiary's accident could have been recovered. However, in many cases, there will be a compromise in the case settlement. For example, a liability carrier will have agreed to pay 50% of medical expenses related to an accident. In this case, the reviewer will assume that the available TPL would have been 50% of the review month expenses, that is, the medical expenses less the percentage of compromise on the claim.

The dollar amount of a TPL error can never exceed the amount that Medicaid paid for review month services for which a third party was liable. However, the dollar amount of a TPL error may be less than what Medicaid paid. For example, if $75 in third party liability was available to pay for a review month service and Medicaid paid $80 for the service and did not recover or take action to recover the TPL, then the amount of the TPL error is $75.

Exhibit 3500-1, following this page, provides guidance to the QC reviewer on whether the dollar amount of third party liability is measurable and how this dollar amount should be computed. The first column in the exhibit lists the types of third party resources that a reviewer may encounter during the MQC process. The second column briefly indicates the factors to be considered in calculating the dollar amount of available TPL. If during the conduct of the TPL review, the dollar amount calculated as shown in Column 3 is less than or equal to Medicaid's payment for the appropriate review month services, then the amount of TPL is the error amount. However, if the amount of TPL is greater than the amount paid by Medicaid for the same services, then the TPL dollar error is the amount paid by Medicaid.

3533 Independence of the TPL Review

During the course of the TPL review, the QC reviewer will not submit third party liability information that is pertinent to the QC review or that may jeopardize the integrity of the review to State Title XIX recovery unit or other State or contractual agencies. However, if, during the course of the review, other information pertinent to Medicaid or third party information not related to the review is uncovered, the reviewer may submit this information to the appropriate unit of the Title XIX agency. For example, the QC reviewer will not submit positive findings of health insurance coverage during the review month until after the QC review is completed. However, if the QC reviewer discovers that health insurance in effect prior to the review month is no longer available, this finding should be reported to the appropriate Title XIX unit.

Subchapter 3230 includes a further description of the reviewer's responsibility for independence of all elements of the QC review.

Exhibit 3500-1

TPL DOLLAR MEASUREMENT GUIDE

THIRD PARTY RESOURCE	IS DOLLAR AMOUNT OF TPL MEASURABLE?	DOLLAR AMOUNT OF TPL
HEALTH INSURANCE		
Major Medical		
All covered expenses subsequent to deductible having been met.	Yes	Covered review month expenses less coinsurance.
Basic Coverage		
Hospital confinement.	Yes	Covered review month expenses less deductible.
Surgery fee.	Yes	Covered review month expenses less deductible.
Doctor's fee for inpatient visit.	Yes	Covered review month expenses less deductible.
Other covered services.	Questionable	As per policy specifications.
CASUALTY INSURANCE		
Homeowners; Owners, Landlords & Tenants; Business Insurance		
Liability		
Adjudicated		
All accident related expenses.	Yes	Accident related review month expenses less percentage of compromise, if claim was compromised.
Non-Adjudicated		
All accident related expenses.	No	Not included in MQC system.
Medical Payment Coverage		
All accident related expenses incurred within one year from accident date.	Yes	Accident related review month expenses up to cumulative total of limits of available policies.

TPL DOLLAR MEASUREMENT GUIDE

THIRD PARTY RESOURCE	IS DOLLAR AMOUNT OF TPL MEASURABLE?	DOLLAR AMOUNT OF TPL
GOVERNMENT PROGRAMS		
Medicare		
All covered expenses.	Yes	Covered review month expenses less deductible and coinsurance.
CHAMPUS		
All covered expenses.	Yes	Covered review month expenses less deductible
Veteran's Benefits		
All covered expenses.	Yes	Covered review month expenses.
OTHER RESOURCES		
Paternity		
-- Confinement expenses were ordered as damages in the paternity action.	Yes	Review month expenses which are confinement related.
-- Medical support in the form of health insurance was ordered in a paternity action and health insurance is available.	Yes	Review month expenses within limits of health insurance coverage. (See Health Insurance)
-- Other medical support ordered in the paternity action.	Yes	Review month expenses as indicated in the order.
Medical Support		
Insurance ordered and available.	Yes	Review month expenses within limits of insurance coverage.
Expenses ordered by Court.	Yes	Review month expenses as indicated by Court.

TPL DOLLAR MEASUREMENT GUIDE

THIRD PARTY RESOURCE	IS DOLLAR AMOUNT OF TPL MEASURABLE?	DOLLAR AMOUNT OF TPL
Products Liability		
Adjudicated		
All accident related expenses.	Yes	Accident related review month expenses less percentage of compromise, if claim was compromised.
Non-Adjudicated		
All accident related expenses.	No	Not included in MQC System.
Malpractice		
Adjudicated		
All accident related expenses.	Yes	Accident related review month expenses less percentage of compromise, if claim was compromised.
Non-Adjudicated		
All accident related expenses.	No	Not included in MQC System.
Worker's Compensation		
Adjudicated		
All accident or disease related expenses.	Yes	Accident or disease related review month expenses less percentage of compromise, if claim was compromised.
Non-Adjudicated		
All accident or disease related expenses.	No	Not included in MQC System.

TPL DOLLAR MEASUREMENT GUIDE

THIRD PARTY RESOURCE	IS DOLLAR AMOUNT OF TPL MEASURABLE?	DOLLAR AMOUNT OF TPL
Automobile		
No-Fault		
All accident related expenses.	Yes	Accident related review month expenses less deductible up to limits of the Law.
Tort Liability		
Adjudicated		
All accident related expenses.	Yes	Accident related review month expenses less percentage of compromise, if claim was compromised.
Non-Adjudicated		
All accident related expenses.	No	Not included in MQC System.
Medical Payment Coverage		
All accident related expenses incurred within one year from accident date.	Yes	Accident related review month expenses up to cumulative total of limits of available policies.

3534 Acceptable Reasons for Incomplete TPL Reviews

If indications of third party liability are found during the case record review or field investigation, the QC reviewer should make every effort to complete the review as failure to do so may invalidate overall State MQC findings. However, there are several conditions under which a TPL review should not be continued. These conditions refer specifically to those cases for which eligibility has been determined. Guidelines for dropped reviews during eligibility determination have been presented in Chapter 3300 and do not apply to the TPL review process.

1. Reviewer cannot verify or deny the existence of a third party resource - If evidence indicates that TPL may exist, but repeated attempts to verify indications of third party liability (through contacts with the beneficiary, third party or other collateral contacts) have not succeeded in obtaining sufficient evidence of the existence or lack of third party liability, the review should be left incomplete. In the instance above, the reviewer will terminate the TPL review and check the "TPL uncertain, third party not verified" item on the review schedule.

2. Unadjudicated Claims - If a casualty situation is in the adjudication process, i.e., liability is not established and no settlement has been made, and no third party resources are available through Medical Payments coverage, the reviewer will terminate the TPL review and enter TPL uncertain ..., Code 4, in Item A of the review schedule.

3540 Preparation for TPL Review

TPL screening should be undertaken on all sampled cases. Before initiating TPL review of a case, the QC reviewer must obtain the TPL information collected during eligibility review and the paid claims records for review month services. The specific element from the MQC eligibility worksheet that will contain TPL information is element 240. In addition, information will be found on the Medical Services and Health Benefits supplemental worksheets. To establish a third party resource, the reviewer must also obtain the paid claims records of sampled cases for the review month and the provider invoices for review month services. Because the reviewer will have to verify third party coverage of specific medical treatments or surgical procedures, he/she will need to know precisely those services received

by the beneficiary during the review month. In most States, information to that degree of specificity will only be available from the provider invoice. Also , the provider invoice may be a source of "leads" to TPL.

After obtaining and matching, by case, the two sets of information described above, the QC reviewer should sort all of the sample cases into the following categories:

Type 1. Cases with an indication of potential TPL and which have claims for services during the review month.

Type 2. Cases with an indication of potential TPL but for which no services were received during the review month.

Type 3. Cases with no indication of potential TPL, with or without paid claims for the review month.

Only Type 1 cases, as described above should be subject to further TPL review. For Type 2 and Type 3 cases, Item A Section VI on the review schedule will be completed and no further TPL review will be conducted.

The reviewer can identify cases with potential TPL for the review month from element 240 on eligibility worksheets and from the supplemental worksheets. At the State's option, and with Regional Office approval, the QC reviewer may also investigate procedure codes, on provider invoices,that may indicate injuries arising from an accident for which a third party may be liable.

3550 VERIFICATION OF A THIRD PARTY RESOURCE

The QC reviewer must establish conclusive evidence of third party liability for review month services. Subchap 3550 describes the verification procedures and verification requirements for most of the sources of third party liability that the reviewer can expect to encounter. Several intentional ommissions have been made in this subchapter. The most notable exclusion is verification of TPL related to probate of deceased beneficiaries' estates. Probate of estates should not be included in the TPL review process. While verification procedures for casualty situations are included in this chapter, once the reviewer determines that liability has not been established or there has been no claims adjuducation and no Medical Payments coverage is available, no further TPL review should be undertaken.

Verification of a third party resource is required if potential for third party recovery is indicated by any of the following:

1. Indicators from the MQC documents, case file, or field investigation;

2. An indicator on a provider invoice that health insurance was available or that an insurance carrier has been billed for a portion of review month charges;

3. Other indicators.

The verification procedures for third party liability review are presented in the next several sections according to the general type of third party resource identified.

3551 Verification of TPL: Health Insurance

The verification process for health insurance includes for each case, the following major activities.

1. Obtain all third party resource information required to verify other health insurance;

2. Obtain all services-related information for review month Medicaid claims;

3. Present the information obtained in Steps 1 and 2, above, and an authorization from the insured for the release of information to the appropriate representative of the third party resource in order to establish the following:

   a. Health insurance was available during the review month;

   b. Some or all of the review month services would have been covered by the available insurance;

   c. What dollar amount of third party liability was available for each review month service.

   In some instances, an employer or a Union Health and Welfare Fund may be able to supply the information noted above. However, in most cases the insurance carrier will be the primary verification source.

4. Obtain documentation of:

   a. The existence or lack of the third party resource;

   b. The dollar amount available through the third party for each specific review month service.

   This documentation may be correspondence, a State inquiry form signed and returned by the third party, or documentation of a similar nature.

To verify health insurance coverage of a Medicaid beneficiary, the QC reviewer will generally need the information listed below. For some categories listed below, several options are given. These options indicate variability in terminology among insurance carriers and policy types.

1. Insurance company name and where to locate a representative - This is provided to every policy holder. If it is a group policy through employment, information may be requested from the employer.

2. Policy identification numbers:

   a. Group, control or policy number - This is usually contained on the card furnished to the insured. If it is not, then the policy is likely to be an employee group policy and this data would be available through the employer.

   b. Contract or certificate number - Information should be available as for "a".

   c. Service code - Blue Cross/BlueShield uses this exclusively.

3. Policyholder's name - The policyholder may not always be an individual. For example, in the case of a Union Health and Welfare Fund, it could be the Local; employment group policies have the employer as the policyholder.

4. Insured's name - The insured will generally be an individual; for example, the Union member or the employee.

5. Relationship of beneficiary to the insured.

6. An authorization from the insured for the release of information - Procedures in the eligibility of QC process instruct the reviewer to obtain this release during the field investigation. For cases where this release was not obtained, the QC reviewer must determine, based on the disclosure policy of the specific carrier involved in the case, whether an authorization must be available. If the release is not available and required by the insurance carrier, the QC reviewer must attempt to obtain it from the insured.

7. A complete description of the review month services for which health insurance may be available - For each review month service, the following information must be available.

   a. Beneficiary's name;

   b. Provider name and address: institution, physician, pharmacy, etc.;

   c. Service dates;

   d. Procedure, services or drug description or name;

   e. Diagnosis: primary and secondary;

   f. Provider charge.

   Depending on the insurance carrier involved the QC reviewer may also need the place of service, the age and sex of the beneficiary, or other information.

After obtaining the information listed in Items 1-7, the QC reviewer contacts the insurance carrier or other verification contact with a request as to whether the services are covered and at what amount.

Procedures for contacts with insurance carriers may vary by State and, possibly, by carrier depending on the cooperative arrangements between the Title XIX QC unit and the insurance carriers within each State. State procedures should, however, include the following elements:

1. Documentation requirements for verification of third party liability by the insurance carrier.

2. A notice to the carrier that the QC inquiries do not represent claims that are being presented for payment and that further specifies the possibility that these claims may be presented for payment at a later date by the Title XIX agency;

3. A standardized method of contact for each insurance carrier and where possible a standardized procedure for contacting all relevant insurance carriers in the State.

3552 Verification of TPL: Government Programs

The verification process where a government program is the liable third party is similar to that for other health insurance. The type of medical services information that must be available corresponds to that listed in Section 3551. However, beneficiary identification and procedures for contracting the third party vary by government program and are presented below.

Medicaid may incur a liability to pay for joint Medicaid/Medicare beneficiaries under the following circumstances:

1. Payment for a Medicare deductible or co-insurance.

2. Payment for services covered by Medicaid but not falling within covered Medicare benefits;

3. Payment for services after exhaustion of Medicare benefits.

Therefore, the QC verification process for Medicare focuses on establishing that one of the conditions listed above was not in effect.

The QC reviewer may be able to determine that Medicaid paid for a deductible or co-insurance amount by examining the provider invoice. If after examining the charge for the service and other pertinent elements of the invoice, the QC reviewer cannot determine conclusively that Medicaid payments were appropriate, the reviewer should follow the procedures for verification that are presented in a later portion of this section. If the reviewer can ascertain that Medicaid paid the appropriate co-insurance or deductible amount, no further TPL review is required.

The QC reviewer may also be able to determine from the provider invoice whether Medicaid paid for a service not covered by Medicare. The service listed on the Medicaid invoice should be compared to Medicare covered services as listed in the Federal regulations for Part A and Part B. If the reviewer cannot ascertain that Medicaid payments were appropriate, he/she should continue TPL review of the case. If the QC reviewer can establish that Medicaid paid for the services not covered by Medicare, no further TPL review is required.

The reviewer generally cannot determine from the provider invoice whether Medicaid paid for services after Medicare benefits were exhausted. Thus, for these cases, further TPL review is required.

To verify Medicare coverage of a review month service, the following beneficiary information must be available.

1. Beneficiary name;
2. Birth date;
3. Current address;
4. Social Security number and/or Social Security claim number;
5. Name and Social Security number of head of household in cases involving dependent children.

In addition, the medical services information listed in S 3551 must be available as well as a beneficiary authorization for the release of information.

The source of verification of Medicare coverage of review month services is the District Social Security Administration Office.

While the State Data Exchange (SDX) tapes furnished to the States by the Social Security Administration (SSA) will identify SSI beneficiaries who are eligible for Medicare and additional information may be available from "buy-in" records where the State has availed itself of the option of buying Part B coverage for qualified Medicaid beneficiaries, this data will generally not be sufficiently specific to determine whether review month services were covered by Medicare and, if so, in what amount.

To verify the availability of CHAMPUS as a third party resource, the QC reviewer must obtain the data specified by the Office of Civilian Health and Medical Program of the Uniformed Services (OCHAMPUS) on OCHAMPUS DA Forms 1863-1 and 1863-2. The 1863-1 form is the form used by civilian hospitals to bill OCHAMPUS for services and supplies delivered to CHAMPUS beneficiaries and contains the policyholder's (i.e., serviceman's) name and service number and all pertinent information on medical services delivered. The 1863-2 form is used for billing by providers other than civilian hospitals.

The identifying information should be available from the eligibility and supplemental worksheets. However, if that information is not sufficiently specific, then the appropriate branch of the Armed Services should be contacted in order to obtain the elements of identification specified on Forms 1863-1 and 1863-2.

To obtain validation of coverage from CHAMPUS, the QC reviewer will need to submit the identifying information and medical services information noted above, with a copy of the provider's invoice that was paid by Medicaid to the designated. State CHAMPUS fiscal intermediary (also known as fiscal administrators).

To verify Veteran's Benefits as a third party resource, the QC reviewer must obtain beneficiary identification and medical services information sufficient for the Veteran's Administration to determine whether the individual is eligible for V.A. medical benefits and whether specific review month services would have been delivered to the individual by V.A. facilities or covered on a fee basis. Appropriate individual identifiers include the beneficiary name and Social Security number (or, for some older Veterans, the V.A. Claim Number). The services identification information listed under Item 7, Section 3551 is generally sufficient for V.A. related QC TPL reviews with the addition of the condition for which the medical service was sought. To verify V.A. coverage of review month services, the complete data set should be submitted to the Veteran's Administration. If a beneficiary has received services at a Veteran's Administration facility (hospital) and this is known to the QC reviewer, verification inquiries should be directed to that facility. If

the QC reviewer cannot identify a V.A. hospital which has served as a source of care to a Veteran, the QC reviewer should contact the appropriate Regional V.A. office to verify TPL.

3553 Verification Of TPL: Liability/Casualty Insurance

Verification procedures for casualty insurance involve three major tasks. These are as follows:

1. Determine which review month services paid by Medicaid were associated with the injury or illness caused by the accident for which TPL may be available;

2. Determine whether a third party has been deemed liable for payment of the accident-related medical claims;

3. Determine the dollar amount available from the third party to cover accident-related review month services.

Each of these tasks is discussed in this section.

To determine which review month services were associated with the accident, the QC reviewer will rely on the following sources of information:

1. The beneficiary's statements as recorded on the supplemental medical services and Health Benefits worksheet.

2. Information obtained through the TPL QC reviewer's contacts with the beneficiary or his legal representative;

3. Statements of providers who delivered the review month services.

Only those review month services that are clearly treatments for accident-related injuries or illnesses are to be included in this type of TPL QC review.

The extent of the investigative process that will be required to determine whether there is third party liability in a casualty situation will be somewhat dependent on the amount of information that was obtained during the eligibility field investigation. If minimal information is available, the QC reviewer may need to contact appropriate agencies or individuals and examine the following types of documents:

1. Accident reports of the involved parties;

2. Accident reports of the investigating officers;

3. Department of Motor Vehicles records;

4. Public records of institutions or governments;

5. Statements and other information obtained from witnesses;

6. Employer accident records;

Guidance on what items of information, from the above listed sources, will be useful to the reviewer is given in Subchap 3466.

The QC reviewer will need the following information concerning the accident or occurrence in order to investigate the availability of third party liability in instances where casualty insurance policies are or may be in effect:

1. Homeowners; Owners, Landlords & Tenants; Business Liability; Malpractice; and Products Liability require similar data which is as follows:

   a. Person who caused accident or owner of premises;

   b. Address of person or premises where accident occurred;

   c. Insurance company which covers premises or person (including insurance company address and the address of its local representative;

   d. Policy number of claim number;

   e. Accident date;

   f. Nature of injury;

   g. In the case of products liability, determine the product involved responsible for the injury and its manufacturer;

   h. In the case of malpractice, determine the service that was performed improperly by whom, and the resulting injury.

2. Workmen's Compensation:

   a. Date of illness or injury;

   b. Employer's name and address at time of illness/injury;

   c. Employee's department, division, etc.;

   d. Employer identification number;

   e. Workmen's Compensation carrier and address;

   f. Policy number or claim number.

3. Automobile:

   a. Date of accident;

   b. Place of accident (State, county, city/ town and streets);

   c. Names and addresses of drivers;

   d. Names and addresses of owners of vehicles;

   e. Insurance companies of owners of vehicles and drivers;

   f. Addresses of insurance companies of owners and drivers;

   g. Policy numbers and/or claim numbers of owners and drivers insurance companies;

   h. Insurance company of beneficiary;

   i. Address of beneficiary's insurancy company.

For automobile accidents, it may be possible to "stack" additional insurance policies other than those listed above. However, the QC reviewer will need to examine his/her State laws to determine the potential liability of third parties other than those listed above.

Sources of verification of third party liability in casualty cases will include the following, depending on the nature and place of the accident:

1. Insurance carriers;

2. Employer's and Workmen's Compensation carriers;

3. Attorneys;

4. Court records.

The reviewer should contact these sources to establish the following:

1. Whether liability insurance was available and whether liability has been acknowledged or denied;

2. Whether a claim has been adjudicated under any of the available policies, either through settlement or through a court order;

3. Whether any benefits have been paid to the beneficiary, his legal representative, or to Medicaid;

4. The amount for which the third party was found liable, the amount of the settlement, etc.;

5. Whether Medical Payments insurance coverage was available under any of the insurance policies involved (products liability and malpractice insurance will not carry this type of coverage);

6. The dollar amount available under Medical Payments insurance coverage.

If the QC reviewer cannot clearly establish a minimum dollar amount of third party resources that was available to cover service claims during the review month, no further TPL review is required. If any of the following conditions are found, the TPL QC review should continue:

1. A court ordered award or otherwise adjudicated claim for all or a specified amount of medical expenses and/or other damages under any type of insurance policy;

2. Payments of Workmen's Compensation benefits to the beneficiary and payment of medical expenses to a provider;

3. Availability of a specified amount of Medical Payments insurance benefits and the accident occurred within one year of the review month;

4. Availability of no-fault automobile insurance.

3554 Verification of TPL: Other Third Party Resources

Where applicable, the QC reviewer will verify the availability of third party resources other than those listed in Subchapters 3551 through 3553 if a legal basis for these resources exists in the individual State. Verification of two of these other third party resources, paternity confinement expenses and medical support, are discussed in this section. The State may choose to include other third party resources with the approval of the Regional Office.

Verification of paternity confinement expenses is appropriate when childbirth related medical services (mother or infant) during the review month have been paid by Medicaid and when this expense is recoverable by Medicaid under State law. The QC reviewer must verify, through the beneficiary, her legal representative or court records, that a court order or voluntary commitment for a specific amount of damages has been made.

Verification of medical support in absent parent cases requires the reviewer to obtain and examine the court order for this support and to determine the nature of the support, the dollar amount, and conditions under which this support is available. Sources of the court order will include the beneficiary, the court records and the Office of Child Support Enforcement.

If case documents indicate that medical support is available through health insurance, the verification procedures in Section 3551 must be followed. If court ordered or voluntary medical support is in the form of medical expense payments, the QC reviewer must establish that the medical expense payments should have been applied to all or part of the review month service claims paid by Medicaid. For example, if medical expenses were ordered in the amount of $50 per month, this $50 may have been expended prior to Medicaid's payments for review month services, i.e., the claims paid by Medicaid represented the balance of review month services after exhaustion of medical support payments. To make this determination, the QC reviewer may need additional information from records of the beneficiary, absent parent, provider or Office of Child Support Enforcement.

In some cases of court ordered medical expense payments, there may be some doubt as to the absent parent's ability to meet these commitments. In these cases, the criteria used for that purpose by the State IV-D agency should be applied by the TPL QC reviewer. Use of State IV-D agency criteria for the level of effort to be applied in locating an absent parent is also appropriate.

3560 VERIFICATION OF STATE ACTIONS TO RECOVER THIRD PARTY FUNDS

As noted in Subchapter 3530, a TPL error cannot occur unless three conditions have been met. Therefore, for those review month service claims where the QC reviewer has been able to verify a third party resource, before an error can exist the reviewer must verify that the State Title XIX agency has not recovered or sought to recover the available third party funds within 30 days after the end of the month in which the TPL covered claim(s) was paid.

The reviewer must obtain evidence that:

1. The sample claim or case had been referred to the appropriate State Title XIX organizational unit with responsibility for third party recovery;

2. The organizational unit with that responsibility had recovered or taken action to recover the available amount of third party laibility for review month services.

The specific organizational unit with responsibility for third party recovery will be identified to the QC reviewer by State administrative officials. If two or more units share responsibility for the recovery process, the reviewer must verify that none of these units has sought recovered or to recover third party funds for the case under review.

The State Title XIX agency may contract with other State agencies or non-governmental organizations for the purpose of third party recovery for all or some beneficiaries. For example, proposed Federal regulations for Public Law 94-142, the Medicare-Medicaid Anti-Fraud and Abuse Amendments, specify that cooperative arrangements be developed between the State Title XIX agency and the State Office of Child Support Enforcement (Title IV-D) for the purpose of medical support enforcement. In those States where the Title IV-D agency has contracted with Medicaid to undertake recovery of third party funds in absent parent cases (whether the medical support is through health insurance or medical support payments), the reviewer will need to establish that the Title IV-D agency has recovered or sought to recover available third party funds. The same will be true if other governmental or non-governmental agencies are under contract to Medicaid to perform third party recovery activities.

The primary method for verification of State recovery of third party funds is examination of the records of the appropriate organizational unit. The QC reviewer should schedule and conduct these review procedures so as to cause minimal disruption to the operation of the unit responsible for recovery. Another consideration in verification of State actions is confidentiality and independence of the QC review. The reviewer should assure that the verification process is based on past and current actions of the recovery unit; that is, the reviewer must assure that records on a case are not developed subsequent to a request for information on a case. For example, if the QC reviewer requests a case TPL file from the recovery unit and is told that it is currently unavailable, the reviewer should request a description of the file's contents and attempt to verify State actions through collateral contacts. This may mean contacting an insurance company, beneficiary or lawyer to verify that the State actions about which the reviewer has information have been taken within the specified time frame.

Because the QC reviewer must verify that a State took action to recover third party resources within 30 days after the end of the month in which the claim was paid, in some cases the QC review may occur after a case has been closed by the "recovery unit." If the unit(s) responsible for recovery does not maintain historical files, the QC reviewer (QC unit) will need to establish a procedure through which he may determine whether closed cases correspond to QC sample cases. Several options are available. The QC unit can request the "recovery unit" to inform them periodically of cases being closed so that the QC reviewer can salvage needed records prior to their disposal. Alternatively, the QC unit may request that the recovery unit maintain a file of closed cases for a 6-month period or the QC unit may offer to maintain these records in the central or local QC offices. Procedures developed by a State for the above purpose should be submitted to the Regional/MQC Office for approval.

The following will be sufficient evidence that a State has recovered or sought recovery of a TPL covered claim:

1. Documented notification of loss to a third party carrier or to a legal representative of a beneficiary requesting verification of a third party resource;

2. Correspondence or other documents provided to a third party resource which indicate that an investigation seeking recovery is underway;

3. Documented record of a claim filed with the third party by the "recovery unit" requesting reimbursement;

4. A record indicating that payment of the specific TPL covered claim (s) under review has been obtained from a third party.

3570 TPL WORKSHEETS AND ERROR CALCULATION

This section presents a worksheet for the TPL reviewer to use to summarize the findings of the TPL QC review and the procedure for determination of errors based on the use of the worksheet.

Implementation of the review process presented in subchapter 3540 3550, and 3560 should result in all of the information necessary to complete the worksheet for those cases where TPL was available. For review cases not found to involve third party liability, or found to have no claims for the review month, completion of the worksheet is not necessary. However, lack of TPL is entered on the review schedule which must be completed for every sample case. Instructions on completion of the TPL portions of the review schedule appear in subchapter 3580.

Exhibit 3500-2, following this page, depicts the worksheet for TPL review. Findings from the QC review should be entered during the elements shown in the column headings. Specific instructions are given below.

A completed worksheet will contain all TPL findings for one case. The review number of the case is entered in the top left hand corner. The names of the beneficiaries in the case are entered in Column 1. For each beneficiary claim, the claim number, the date on which Medicaid paid the claim, and the amount Medicaid paid on the claim should be entered in Columns 2,9, and 8, respectively. The reviewer should ascertain that the amount entered in Column 8 is the amount Medicaid paid, not the amount of the provider invoice in the case that these two amounts differ. In Column 3 of the worksheet, the QC reviewer should enter the type of service for which Medicaid paid a claim covered by TPL. The service codes to be used are given in exhibit 3500-4 on page 52.

In Column 4 the reviewer should enter the dollar amount of claim.

In column 5 of the TPL review worksheet, the QC reviewer enters the identifiying information on verified third party resources. This item reflects the name of the liable third party payor and identification of the contractual basis under which he is liable. This second item would be, for example, specific policy numbers and a brief notation on the type of policy in effect. The reviewer must not include in Column 5 any third party liability that does not cover all or part of the specific claim under consideration.

Column 6 allows the reviewer to code the available third party resources according to the classification code to be used for completing the Review Schedule. The TPL codes for use during the MQC review are shown in exhibit 3500-5 on page 53.

Column 7 provides for recording of the specific dollar amount of available TPL. The reversed side of the Third Party Liability worksheet may be used as required.

Form HCFA-301 D (3/78)
Department of Health, Education and Welfare
Health Care Financing Administration

OMB No. 066-R-0107
Expires 3/79

EXHIBIT 3500-2
THIRD PARTY LIABILITY REVIEW WORKSHEET

Review No. _____

1. Case Name	2. Case ID Number	3. Review Month	4. Reviewer

A. No. of Claims with TPL	B. Types of Service with TPL Error	C. Types of TPL Available	D. Dollar Amount of TPL	E. No. of Claims w/ TPL Error	F. Dollar Amount of TPL Error
	☐☐ ☐☐ ☐☐ ☐☐	☐☐ ☐☐ ☐☐ ☐☐			

1. Beneficiary Name	2. Claim Number	3. Type of Service	4. Dollar Amount of Claim	5. TPL Resource (identify)	6. Type of TPL (code)	7. Dollar Amount of TPL Available for Claim	8. Dollar Amount of TPL Paid by Medicaid	9. Date of Medicaid Claim	10. Date of Medicaid Payment and Date of the State Action	11. State Action to Recover	12. Dollar Amount of TPL Error	Source of TPL Error: 1. Certifying Agency; 2. Beneficiary; 3. Claims Processing; 4. Recovery Activities

EXHIBIT 3500-2
THIRD PARTY LIABILITY REVIEW WORKSHEET
(continued)

1. Beneficiary Name	2. Claim Number	3. Type of Service	4. Dollar Amount of Claim	5. TPL Resource (identify)	6. Type of TPL (code)	7. Dollar Amount of TPL Available for Claim	8. Dollar Amount of TPL Paid by Medicaid	9. Date of Medicaid Payment	10. State Action to Recover and Date of the State Action	11. Dollar Amount of TPL Error	12. Source of TPL Error 1. Certifying Agency 2. Beneficiary Processing 3. Other 4. Recovery Activities

Exhibit 3500-1, shown in subchapter 3532, depicts how the available TPL may be calculating for various liable third parties. The reviewer should assure that all computations of available third party dollars reflect appropriate deductibles and co-insurance required by most insurance policies and government programs. In calculating the dollar amount available for casualty situations, the reviewer should assume that the total amount of TPL available can be used for coverage of review month services if no previous claims have been made by the State. For example, if a liability suit has resulted in an award of $400 for medical expenses and the review month claims are for $200, then the amount of available TPL will be $200. There is one exception to this rule. In many cases, the reviewer will have verified that the third party (ies) will pay and/or has paid "x" percentage of the medical bills; e.g., 50%, 75%, etc. In these cases, the reviewer will consider the available TPL $'s to be the specified percentage, e.g., 50%, of the casualty related review month claims. For example, if the casualty related claims are in the amount of $200 and the third party liability is 25%, then the dollar amount of available TPL (Column 7) is $50.

In computing available TPL in a liability/casualty case where verified Medical Payments coverage and liability insurance are available, the total amount of available Medical Payments coverage is applied to review month accident related expenses prior to application of a compromise (i.e., percentage) payment under liability insurance. For example, if accident related review month expenses paid by Medicaid are $800, available Medical Payments coverage is $500, and the liability policy paid off at 50% of medical expenses, then the $ amount of available TPL will be calculated as follows:

Computation

$800 - Review month, accident-related claims paid by Medicaid
- 500 - $ available from Medical Payments coverage
300 - Amount of claims not covered by Medical Payments coverage
x .50 - Compromise on Liability coverage (50% of excess expense)
150 - $ available from Liability coverage

$650 - TOTAL $ TPL AVAILABLE: $500 Medical Payments coverage plus $150 from liability coverage

Computations such as that above should be shown on the back of the worksheet.

Column 10 of the worksheet is used to document whether a State has taken action to recover third party funds and, if so, the date that this action was taken. The procedures for obtaining this information have been described in subchapter 3560. In Column 10, the QC reviewer

should briefly note the action that was taken by the State, if any action has been taken. Appropriate notations of actions would be "claim filed with Blue Cross; 12/3/78", "letter with notice of loss to Traveler's Insurance, 11/8/78", ect. If no action has been taken by the State, that fact should be entered in Column 10 the date entered in Column 10 should reflect the first date of State action if an action to recover has been taken or should be a date after the end of the administrative period is over, if no action to recover has been taken.

The entry in Column 11 of the TPL review worksheet will represent the dollar amount of the TPL error for one review month claim. Summation of all entries in Column will provide the total dollar amount of TPL error for a case. An error amount is only possible when a third party resource has been verified and no recovery or State action to recover has been made during the appropriate time period If appropriate action State action was undertaken within 30 days after the end of the month in which the claim was paid, then the entry in Column 11 will always be 0.

The amount entered in Column 11 can never exceed the amount entered in Column 8; that is, the error amount can never exceed the amount Medicaid paid on the claim. Therefore, if the amount of available TPL (Column 7) exceeds what Medicaid paid (Column 8) and if the State took no action to recover, then the dollar value of the TPL error will be the amount paid by Medicaid. If the amount for which a third party is liable is less than the amount paid by Medicaid, the amount covered by the third party is the error amount.

Column 12 Source (s) of TPL Error, is completed only when an error amount (other than "0") is entered in Column 11. The entries in Column 12 reflect why a TPL error occured and identify sources of TPL errors in State operations. The errors and associated codes to be used on the worksheets are as follows:

1. Certifying Agency - Failure of the State to identify TPL during eligibility determination or redetermination; as a result of changes of status.

2. Beneficiary - Failure of the beneficiary to inform Medicaid of potential TPL;

3. Claims Processing - Failure of Medicaid claims process screening for TPL;

4. Recovery Activities - Failure of the State to investigate or adequately pursue available TPL leads.

States may add other TPL error codes at their discretion, but new Codes may not be substituted for Codes 1-4 listed above.

The reviewer should code all errors contributing to the third party error. It should be noted that some of the errors listed above are mutually exclusive. For example, Codes 1 and 2 connot be entered for the same claim; either the local agency failed to identify TPL or the beneficiary did not notify the certifying agency when TPL became available. If TPL became available after the last eligibility action and the beneficiary did not inform the certifying agency, then Code 2 error is entered. If the review worker failed to identify available TPL at the time of the last eligibility action then Code 1 error is entered.

Claims processing cannot be entered as a source of TPL error unless TPL information was made available to claims processing through appropriate State channels. Code 3 errors will generally occur due to lack of claims processing screening against eligibility information or failure to up-date the claims processing files with TPL data.

Code 4, FAILURE TO INVESTIGATE or adequately pursue available TPL leads known to the agency, is used when no appropriate action has been taken by the appropriate State agency on those review cases where there were indications of TPL.

After completing columns 1-12 of the worksheet, case summary TPL QC results should be entered in Items at the top of the worksheet.

Items B, C, D, E, I, and J should be completed as follows:

B. Number of claims with TPL available: This entry corresponds to the count of the non-zero entries in column 7 of the worksheet.

C. Types of Services with TPL error - For those claims shown in Column 11 to have a TPL error, the service codes entered in Column 3 should be entered in Item C.

D. Types of TPL - The TPL codes entered in column 6 of the worksheet should reflect verified third party resources. These codes should be entered in Item D at the top of the TPL worksheet (codes exhibit 3500-5 Item D.

E. $ Amount TPL Available - The sum of the entries in Column 7 of the worksheet provide the entry for Item of the summary.

I. Number of Claims with TPL Error - The entry for Item I of the TPL summary is obtained by counting the number of non-zero entries in Column 11 of the TPL worksheet.

J. Dollar Amount of TPL error - The entry for item J of the TPL summary is obtained by totalling the dollar value of non zero items in column 11.

3580 COMPLETION OF THE REVIEW SCHEDULE FOR THIRD PARTY LIABILITY

After calculating the dollar value of TPL errors for all claims for case members during the review month the QC reviewer must document the TPL findings on the review schedule. This section of the Manual providers instructions for item by item completion of the review schedule, which is shown as Exhibit 3500-3, following this page.

I. Identifying Information

1. Case Name - Erter the full name of the head of the Medicaid assistance group.

2. Address - Enter the complete address where the case members resided at the time for the review.

3580 COMPLETION OF THE REVIEW SCHEDULE FOR THIRD PARTY LIABILITY

After calculating the dollar value of TPL errors for all claims for case members during the review month must document the TPL findings on the review schedule. This section of the Manual provides instructions for item by item completion of the review schedule, which is shown as Exhibit 3500-3, following this page.

I. Identifying Information

1. Case Name - Enter the full name of the head of the Medicaid assistance group.

2. Address - Enter the complete address where the case members resided at the time for the review.

3. Case Identification Number - Enter the number used by the State agency to identify the case.

4. Review Month - Enter the month and year for which third party liability was reviewed.

5. Date Assigned - Enter the date (Month, day, year) the case was assigned to the reviewer.

6. Date Completed - Enter the date (month, day, year) the reviewer completed his investigation and has made the determination of third party laibility.

7. Reviewer (Name or Number) - Enter the name or number assigned to the reviewer.

VI. Summary of Third Party Liability TPL Errors

A. TPL Status - For each sampled case, a TPL finding should be entered in Item A. One of the five codes listed must be entered. The TPL Status codes are as follows:

1. No TPL Present - Use this code on the review schedule if no evidence of any type of third party liability (e.g., insurance company, other government programs, etc.) is verified during any phase of the QC review process.

2. TPL present,no claims for the review month - Use this code on the Review Schedule if the QC worksheets (Element 240)or other information verifies the existence of third party liability but there are no claims for service during the review month or no claims for services covered by TPL.

EXHIBIT 3500-3
TPL REVIEW SCHEDULE

Review No._____

Form HCFA-301 Page 3 of 5 VI. Summary of Third Party Liability Errors

1. Case Name	2. Address	3. Case ID Number

4. Review Month	5. Date TPL Review Assigned	6. Date TPL Review Completed	7. Reviewer

(Card 4: Duplicate columns 1-15 from card 1)

A. TPL Status (check one) [16]

1. ☐ No TPL present
2. ☐ TPL present, no claims for the Review Month
3. ☐ TPL present, dollar amount verified
4. ☐ TPL uncertain, third party not verified
5. ☐ TPL present, dollar amount can not be determined

B. Number of Claims with TPL Available [17 18 19]

C. Types of Services with TPL Available [20 21] [22 23] [24 25] [26 27]

D. Types of TPL Available [28 29] [30 31] [32 33] [34 35]

E. Dollar Amount of TPL Available [36 37 38 39 40]

F. TPL Errors by Type of Service

	service code	frequency	dollar amount
1.	[41 42]	[43 44]	[45 46 47 48 49]
2.	[50 51]	[52 53]	[54 55 56 57 58]
3.	[59 60]	[61 62]	[63 64 65 66 67]
4.	[68 69]	[70 71]	[72 73 74 75 76]

(Card 5: Duplicate columns 1-15 from card 1)

G. TPL Errors by Type of Third Party Liability

	TPL-type code	frequency	dollar amount
1.	[16 17]	[18 19]	[20 21 22 23 24]
2.	[25 26]	[27 28]	[29 30 31 32 33]
3.	[34 35]	[36 37]	[38 39 40 41 42]
4.	[43 44]	[45 46]	[47 48 49 50 51]

(Card 6: Duplicate columns 1-15 from card 1)

H. TPL Error by Source of Error

	frequency	dollar amount
1. Certifying Agency	[16 17]	[18 19 20 21 22]
2. Beneficiary	[23 24]	[25 26 27 28 29]
3. Claims Processing	[30 31]	[32 33 34 35 36]
4. Recovery Activities	[37 38]	[39 40 41 42 43]

I. Number of Claims with TPL Error [44 45 46]

J. Total Dollar Amount of TPL Errore [47 48 49 50 51]

3. TPL present, dollar amount verified - Use this code on the Review Schedule if the QC reviewer can verify that a third party was liable to pay for all or a portion of the claims for services received during the review month and the QC reviewer can verify the specific dollar amounts of third party coverage for claims for service received during the review month.

4. TPL uncertain, third party not verified - Use this code on the Review Schedule when there is evidence of TPL resources but the QC reviewer cannot establish a third party's liability for payment for services received during the review month.

5. TPL present, dollar amount cannot be determined - Use this code on the Review Schedule if the QC reviewer can establish that a third party was liable for payment for services received during the review month but cannot determined the dollar amount of this liability.

B. Number of Claims with TPL Available - The QC reviewer should enter the total number of claims for which a third party's liability was verified, regardless of whether these claims resulted in a TPL dollar error. The TPL review worksheet is the source for completion of this item. Three digits should always be entered in Item B, e.g., 0 0 3.

C. Type of Services with TPL Error - The type of service indicated on claims with TPL errors will be entered using the service codes listed in Exhibit 3500-4 on page 53. If more than 4 services are associated with TPL errors, the order of priority for recording services on the review schedule will be based on the absolute dollar value of the TPL error. Enter service code for the largest dollar errors first in descending order.

D. Type of Third Party Liability - The reviewer should enter in Item D the types of third party coverage that were available for all claims with TPL errors. While it is unlikely that more than one type of third party liability will be encountered in any one case under review, space has been provided for recording up to three different third parties. Codes for use in identifying the various third party resources are given Exhibit 3500-5. A two digit code should be entered for each liable third party. Zeros up to six digits when less than three liable parties exist.

E. Dollar Amount of TPL Available - The dollar amount that was available from third parties to pay for review month services should be entered in Item E. This amount was calculated by the reviewer to complete Item C of the TPL review worksheet. Dollar amounts can only be entered here when Code 3 was entered in Item A. Five digits must be entered in Item E, e.g., [0|0|5|7|3]. The dollar amount of TPL available should be rounded to the nearest dollar, i.e., $573.49 is entered as [0|0|5|7|3].

F. Dollar Amount - and frequency of types of services TPL errors. The QC reviewer will enter the dollar amount of TPL found in column 11 and type of services errors found in column 3. Service codes are listed in exhibit 3500-4. If more than 4 services are associated with TPL services errors the order of priority for recording dollar amount and the types of services on the review schedule will be based on the largest dollar errors first in descending order.

G. Dollar Amount and frequency of type of TPL resource errors, The QC reviewer will enter the dollar amount of TPL error found in column 11 and type of TPL error resources errors found in column 6. TPL resource codes are listed in exhibit 3500-5 and should be listed on the Review Schedule with priority based on the largest dollar error first in descending order.

H. Sources of TPL Error - Section 3570 discusses the 5 error types. The number of errors associated with each Code (1-4) should be entered into the appropriate boxes. This information is located in Item B of the TPL review worksheet.

I. Number of Claims with TPL Error - The number of claims with TPL errors, is available from Column 11 of the TPL review worksheet. Three digits must be entered for Item F.

J. Dollar Amount of TPL Errors - The QC reviewer will enter the total number of dollars that Medicaid paid in error as computed on the TPL review worksheet summary. This figure is Item J on the TPL review worksheet. This is a gross dollar amount and is not to be adjusted for eligibility or claims processing dollar errors. This adjustment will be made in VIII. Summary of Payment Errors.

EXHIBIT 3500-4

SERVICE TYPE CODES (ITEM G)

	Type of Service	Code
I.	Institutional Services	
	Inpatient hospital:	
	General hospitals	01
	Mental hospitals	02
	Skilled nursing facilities	03
	Intermediate care facilities:	
	Facilities for mentally retarded	04
	ICF services in all other institutions	05
II.	Noninstitutional Services	
	Physicians's services	11
	Dental services	12
	Other practitioners' services	13
	Outpatient hospital services	14
	Clinic services	15
	Laboratory and radiological services	16
	Home health services	17
	Prescribed drugs	18
	Family planning services	19
	Other services	20

EXHIBIT 3500-5

CODES FOR THIRD PARTY RESOURCES (ITEM H)

Type of TPL	Code
Health Insurance	
Blue Cross/Blue Shield	01
Other Commercial Health Insurance - Group	02
Other Commercial Health Insurance - Individual	03
Government Programs	
Medicare - Part A	10
Medicare - Part B	11
CHAMPUS	12
Veterans Benefits	13
Casualty Insurance	
Automobile Insurance	21
Other Casualty Insurance - Liability	22
Other Casualty Insurance - Medical Payments Coverage	23
Other Third Parties	30

3600 CLAIMS PROCESSING QC REVIEW

This chapter contains procedures for conducting claims processing quality control review. It describes the purpose and scope of claims processing review as well as the specific methodology used in performing such reviews. The discussion includes definitions of a claim, a claim processing error, and specific kinds of error situations. It also describes the documentation needed for the review, the instructions for conducting the review and how the findings are to be recorded and tabulated.

3610 PURPOSE AND SCOPE OF THE QC REVIEW PROCESS

This subchapter presents the purpose and scope of the review, definitions of claims and claims processing errors and a general description of the review process.

3611 Purpose of QC Review

To understand the purposes of the quality control claims processing review it is first useful to describe in general how claims processing systems operate. Claims processing procedures begin after claim is received by the Medicaid agency or its fiscal intermediary. Once the provider's claim is received, decisions have to be made as to whether or not a check will be issued and the dollar amount of the check. In order to make these decisions, the claim has to be examined in various ways.

First, the claim has to be examined to ensure that it contains all required information and that the information is internally consistent. Also, it has to be examined to ensure that the recipient who received the service and the provider who submitted the claim were eligible on the date of service. Next, the provider claim is examined to determine if it conforms to program policies and regulations.

If the claim conforms to these requirements, a decision is then made as to the dollar amount to be paid. The dollar amount paid is determined by appropriate fee schedules and fiscal policies. The dollar amount paid is responsive to service requirements and categorical relationship. All of these procedures follow the State's claims processing requirements. If the system is automated, the edit checks will often be extensive for reviewing these requirements.

The purpose of the claims processing review is to identify claims which were paid incorrectly according to applicable State policy at the time services were received by any members of the sample case. The claims processing QC review examines paid claims

to determine if and where erroneous payments were made. By so doing, the number and amount of erroneous payments can be determined for all paid claims relating to sample cases for any review month. The paid claim information for the sampled cases can then be used for estimating the number and dollar amount of erroneous payments for all cases in the universe.

The QC claims processing review will also provide corrective action information regarding the causes and sources of errors. For example, the information may indicate that dollar amounts paid for a particular type of services exceeded the allowable charges or that payments were made for services not allowable under the State plan. Such information enables corrective action to be taken which reduces the identified types of errors.

3612 Scope Of The QC Review

In the claims processing QC review, paid claims associated with members of the sample cases reviewed for eligibility and third party liability are examined. For consideration in the claims processing QC review, a claim must already have been paid by the State or its fiscal intermediary and represent payment for service(s) delivered to a case member during the QC review month (or partial month) for that case.

Claims are contained on provider invoices. A claim is a charge by a provider for a service delivered to a specified beneficiary. Normally, a claim is filed for a single drug prescription, a single physician office visit, etc. When the provider invoice states a single dollar amount for more than one service for which the provider manual or fee schedule requires a separate charge, such as inpatient hospital days, the reviewer will have to separate each service and assign a prorated dollar amount. In such cases, the reviewer will also have to assign the date of service to each claim.

Often for nursing home stays, the State provider manuals and fee schedules allow payment for more than one day of care, such as weekly or monthly rates. In these situations, the reviewer will not separate the payment into days of service. The charge will be considered as one claim and its appropriateness will be reviewed in terms of the State's inclusive rate policy and fee requirements. If other services beyond the inclusive rate are listed, each of these services will be considered a separate claim.

The claims processing QC review is not limited to the provider invoice information. It includes examination of supporting documentation such as prior authorization forms. In those States which have prior authorizations or physician's certifications as separate documents, the reviewer will have to obtain such documents and utilize the necessary authorization, dates of service authorized and types of services authorized in determining the appropriateness of the paid claim.

It is possible that a provider invoice will state a single lump sum charge for services which are required by the State provider manuals

and schedules to be reimbursed on a unit of service basis. Where possible, the reviewer will separate these claims for services into discrete service units and assign dollar amounts. For dollar amounts which cannot be assigned, the reviewer will consider the total dollar amount not assigned to be in error and coded in a nature code of Element 710 of the Error Situation Profile.

The specific situations that can lead to erroneous payments are listed in Subchapter 3620. There are other claims processing errors that can occur. However, for purposes of QC review, only those listed in the Error Situation Profile are to be considered errors. The total number of errors and the dollar amount of those errors are totalled for each case in the sample. In addition, the specific location and nature of errors made are determined; e.g., a processing error in a physician claim caused by the physician's ineligibility on the date of service. These tabulations related to the cause of errors are used for corrective action purposes.

Claims that are paid for beneficiaries who were determined ineligible by QC or for which QC review identified third party liability errors are not considered claims processing QC errors. Claims processing QC errors are caused only by claims paid in error due to faulty processing procedures and use of reference files which do not correspond to information contained in case records or other official source documents.

The claims processing QC review recognizes the need for an administrative period to reflect payment corrections made by the State agency or its fiscal intermediary. The administrative period covers the month of and the month subsequent to the month in which the claim was paid. Payment corrections can be made in two ways. One way is the reduction of a subsequent payment to the provider. The second is a written instruction in the payment system to reduce any subsequent payment to the provider. In either situation, the correction must specify the provider, the beneficiary, the invoice or claim for service, and the exact dollar amount of the correction.

3613 General Description Of The Review Process

This Subchapter briefly outlines the process used in conducting the claims processing QC review. To assist in understanding the process, Exhibit 3600-1 graphically depicts the review activities. Complete instructions and documentation requirements follow in appropriate subchapters.

The claims processing QC review examines paid claims for services received by members of a sampled case. All services received in the review month will not be reviewed; only those services for which a claim was paid in the MQC prescribed time period. The review process begins by collecting the provider invoices (claims) from which payments were made for services received by members of the sample case during the review month.

The format of the provider invoices may vary substantially among States. Claims payment copies may be generated by computer, by microfilm, or other data forms. The invoices could be microfilm, microfiche, or actual paper copies of invoices. The paid claims and the invoices copies may be obtained from either the State or the fiscal intermediary claims processing unit.

At a minimum, the following will be needed for claims processing QC review:

1. Medicaid certified provider listing for the month under review;

2. State program provider manuals which define allowed services, their frequency, and any other pertinent program requirements;

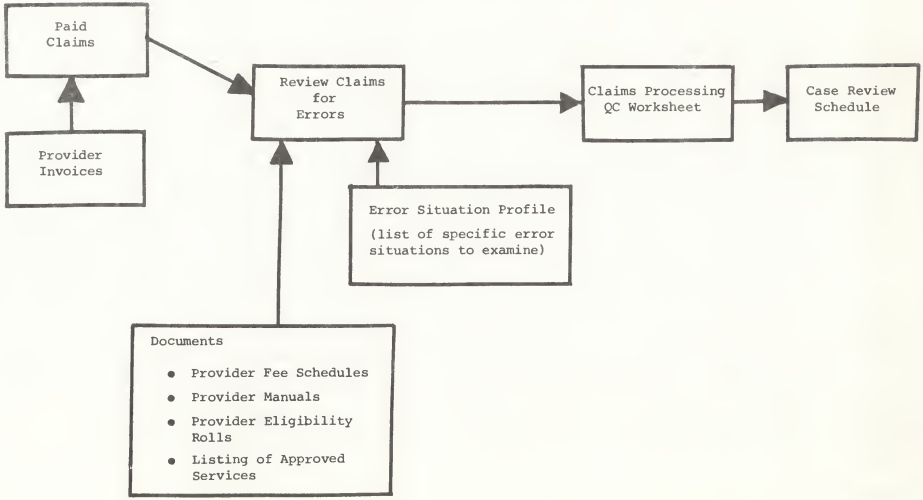
3. State provider fee schedules, reimbursement tables and other information on allowable payments to groups and individual providers; and

4. Listing of approved services.

This information must be current and in conformance with the approved State plan for the review month and enable the reviewer to determine whether the paid claims were for covered services and paid in the proper amount.

EXHIBIT 3600-1

FLOW DIAGRAM OF CLAIMS PROCESSING QC REVIEW



The Error Situation Profile divides possible errors into different provider groups and under each provider group the specific nature of errors that can occur within that group. For example, under the provider group "physicians" there is a specific error and situation entitled, "service not covered." Using the physician's provider manual or other appropriate sources the reviewer would confirm that the service listed in the paid claims record was in fact covered by the State program. For MQC purposes, provider manuals and other source documents may be a combination of letters, instructions, fee schedules, etc. which are official requirements and payment procedures which the provider is to follow. Subchapter 3630 describes source documents which can be used in the claims processing QC review.

The Error Situation Profile defines the kinds of errors that can occur. State policy dictates the applicable portion of this Profile which must be used by reviewers. Thus, the reviewer is only responsible for checking errors listed on the Profile prepared for his or her State. Each possible error is classified by an element (provider, service areas and an element for "completeness of claim"), and by a nature code for the specific error situation. When the reviewer finds an error in a claim associated with a nature code, the reviewer enters the nature code for that error under the appropriate element on the worksheet.

This process is continued for each paid claim and for all beneficiaries within the case. Once the claims review for a case has been completed, the results are entered on the claims processing worksheet. This information includes the case number, beneficiary name(s), the total number of claims, the total number of claims in error, the dollar amount of all claims, and the dollar amount of those in error. The worksheet also contains a table to enter totals of the specific kinds of errors by element and nature code. The information on the worksheet is then transferred to the Case Review Schedule.

3620 DESCRIPTION OF ERROR SITUATION PROFILE

This Subchapter presents detailed descriptions of specific kinds of QC claims processing errors. For QC purposes, claims processing errors are limited to those contained in the Error Situation Profile.

3621 Definition Of Error Elements

The Error Situation Profile presented in Exhibit 3600-2 contains seven elements or broad error situations which make up the QC universe of claims processing errors. These seven elements are:

710 Completeness of Claim
720 Inpatient Hospital Services
730 Physician Services
740 Long Term Care Services
750 Pharmacy Services
760 EPSDT Services
770 Other Services

EXHIBIT 3600-2

ERROR SITUATION PROFILE

Element and Nature Code		
710		Completeness of Claim
	00	No Errors
	01	I.D. Number(s) Missing
	02	Charge not Given
	03	Initials or Signature of Preparer Missing
	04	Additional Information or Documentation Needed
	05	Missing Diagnostic or Procedure Code
	06	Incorrect Computations of Claim
	07	Inappropriate Lump Sum Charge
720		Inpatient Hospital Services
	00	No Errors
	01	Provider Ineligible on Day(s) of Service
	02	Excessive Amount Paid
	03	Payment Covers Services not Allowed
	04	Inpatient Charge when Admission not Certified by Physician
	05	Payment for Institutionalized Patient on Day of Admission and Day of Discharge
	06	Surgery Set-up Charges when Surgery Cancelled
	07	Duplicate Claim
	08	Service Unit not Specified
730		Physicians' Services
	00	No Errors
	01	Provider Ineligible on Day(s) of Service
	02	Excessive Amount Paid
	03	Claims for Items not Covered
	04	No Prior Authorization when Required
	05	Duplicate Claim
	06	Service Frequency Violation
	07	Multiple New Patient Office Visits
	08	Office Visit Pre/Post Surgery
	09	Service Unit not Specified
740		Long Term Care Services
	00	No Errors
	01	Provider Ineligible on Day(s) of Service
	02	Excessive Amount Paid
	03	Claim Covers Items not Allowed

EXHIBIT 3600-2 (Continued)

740 Long Term Care Services

04	Claim for SNF or ICF Where Patient not Certified
05	SNF or ICF Charge After Patient Certification Discontinued
06	Incorrectly Calculated Provider Payment
07	Duplicate Claim
08	Service Unit not Specified

750 Pharmacy Services

00	No Errors
01	Provider Ineligible on Day(s) of Service
02	Excessive Amount Paid
03	Drug not Covered
04	No Prior Authorization when Required
05	Charge for Maintenance Drug in Less than Minimum Quantity
06	Two or More Claims for the Same Drug in the Same Day (Split Claim or Duplicate)
07	Charge for Drug for More Than Maximum Quantity
08	Drug not Specified

760 EPSDT Services

00	No Errors
01	Provider Ineligible on Day(s) of Service
02	Excessive Amount Paid
03	Screening Service for Beneficiary Over 21
04	Second Screening Within Prohibited Period of Time
05	Duplicate Claim
06	Service Unit not Specified

770 Other Services

00	No Errors
01	Provider Ineligible on Day(s) of Service
02	Excessive Amount Paid
03	No Prior Certification When Required
04	No Prior Authorization When Required
05	Duplicate Claim
06	Service Frequency Violation
07	Multiple New Patient Visits
08	Service Unit not Specified

The logic of this Error Situation Profile is that all claims have an associated specific service or provider group and each is subject to unique policies and regulations. All claims can therefore be divided into these individual provider/service groups for purposes of QC review. An exception to this is Element 710 - Completeness of Claim, because it does not have a specific service/provider type orientation. Element 710 is necessary, however, since there are requirements defined by State regulation or policy that refer to information that must be on the claim before it is to be paid. If this information is missing or inaccurate, payment of the claim is considered a QC claims processing error.

The following are individual discussions of each element.

3621.1 Completeness of Claim (710)

A claim should not be paid if the invoice presented by the provider is not fully completed in accordance with State policy or regulation. The reviewer should check to see if I.D. number(s) are missing, if the amount of the charge is given, if the signature of the provider is missing, etc. It is possible for element 710 and another element to be in error in a claim. For example, the beneficiary I.D. number is missing and no prior authorization for service where required. In such cases, the dollar amount in error will be assigned to element 710. Information regarding the other element error(s) will be recorded on the Claims Processing Worksheets and Summary Sheet for corrective action purposes.

3621.2 Inpatient Hospital Services (720)

Paid claims for inpatient hospital services refer to services received by the beneficiary that are directly associated with a period of hospitalization. Depending upon State policy or regulation, these services may be limited strictly to those received while hospitalized or may include some services received just prior to or immediately after the hospital stay. Normally, an invoice for a hospital stay will represent a series of claims for various services such as room accommodation, laboratory service, radiology, pharmacy, operating room, etc. Any of these services billed as a separate total or sub-total represent an individual claim and should be examined separately.

The QC review will be conducted on the basis of the claims and reference documents available to the reviewer. Field investigation is not required to complete the claims processing review.

3621.3 Physicians Services (730)

Payments to physicians should be checked for violation of any of the nature codes indicated in the error profile. Also attention should be given to claims for such services as an initial office visit to determine if the visit should have been included as a follow-up visit. Also, payments should not be made for physician visits to a beneficiary which are billed as part of a hospital's all-inclusive rate. This element also covers physician services received in emergency room, out patient facilities, etc.

3621.4 Long Term Care (740)

This category generally refers to claims paid to nursing homes. Depending upon State policy, these facilities may be skilled or intermediate care facilities. In some cases, long term care may cover domiciliary care and stays in mental institutions. State policy and regulation will define this class of providers.

3621.5 Pharmacy Services (750)

Drug claims may originate from inpatient invoices, physicians, or a pharmacy. The nature codes for this element focus upon payment in accordance with State defined fee schedules, and policies relating to dispensing of drugs in minimum and maximum amounts. Attention should be given to split claims and exact duplicates since these types of errors are common. All drug claims, regardless of origin, should be classified under element 750.

3621.6 EPSDT Services (760)

Claims for these services may originate from a variety of providers and must be identified as EPSDT services for beneficiaries under 21 of age.

3621.7 Other Services (770)

The "Other Services" element covers all services not included above but allowed under State policy and regulation. These can include laboratory testing, home health services, medical equipment and supplies, podiatrists services, eye examinations and eyeglasses, audiological services and hearing aids, Medicare Buy-In payments, and payments to prepaid medical plans (HMOs). A paid claim for every "Other" service is to be reviewed for the nature codes listed in the error profile. A sample listing of Other Services is as follows:

1. Tuberculosis facility for beneficiary less than 65;

2. Mental facility for beneficiary less than 65;

3. Long term TB or phychiatric patient in institution other than TB or certified mental institution;

4. Independent laboratory services not ordered by physician;

5. Home health services not properly certified for patient;

6. Emergency transportation without documentation;

7. Home health agency services provided to a patient in a hospital, SNF, ICF, or government institution;

8. Home health aide claim submitted by member of beneficiary's immediate household;

9. Domestic or housekeeping services;

10. Day care services;

11. "Meals on Wheels";

12. Psychological testing for educational diagnosis, school or institutional placement, or on court order;

13. Custodial care;

14. Physical or speech therapy claim without proof of medical referral by physician;

15. Speech, physical or occupational therapy outside of institution;

16. Services of Christian Science nurses or spiritual healers;

17. Private duty nurse or attendant;

18. Remedial education;

19. Chiropractor services;

20. Audiologist services;

21. Psychologist or social worker services;

22. Routine foot care;

23. Family planning services or supplies;

24. Medical equipment or supplies;

25. Prosthetic devices;

26. False teeth, wigs, artificial breasts, hearing aids;

27. Optical;

28. Dental;

In summary:

1. Any error must be attributable to at least one specific element and nature code.

2. More than one element may be in error; i.e., errors in completeness of information and a service requirement.

3. Nature codes that render in error the entire amount paid must, for QC review purposes, be valued on the basis of the review month only. That is, portions of the paid claim which cover services received prior to and beyond the review month are to be excluded from the claims processing QC review.

4. There is no "other" category in the nature codes. Such a code would, because of its breadth, be meaningless in terms of corrective action. A State may, however, add nature codes to the elements listed as long as these additions are not used to replace those specified in the Error Situation Profile.

3622 Key Nature Codes

A nature code identifies the cause of an error in processing a claim; and tells the reviewer what to check for in reviewing a claim. The key nature codes are as follows:

1. Provider Ineligible on Day(s) of Service - This means that the review should compare the date of service with the provider eligibility file to assure that the provider was, in fact, a certified participant in the program on the day(s) he or she rendered the service.

2. Excessive Amount Paid - The review examines fee schedules and other records of reimbursement limits to assure that the amount paid does not exceed that allowed by the program, or the amount charged by the provider, whichever is less. The code will also be used to determine if other appropriate reductions were made to the dollar amount charged. For example, situations where the beneficiary has a monthly liability for the cost of nursing home care.

3. Claim Paid for a Noncovered Service - Each State Medicaid program pays only for certain specified services. The reviewer will compare covered services with the service provided in the paid claim to assure that it was covered by the State Medicaid program.

4. No Prior Authorization When Required - There are services available for which the provider must obtain written approval from a designated State unit prior to the provision of the service. In those cases where prior approval is specified, the reviewer will check to confirm that this prior approval was obtained.

5. Service Frequency Violations - The reviewer will examine those types of claims that have service frequency limits to assure that the frequency has not been exceeded during the review month.

6. Duplicate Claims - In some instances, claims may be filed which result in more than one payment for a single service provided. The reviewer should check to see if two (or more) claims for the same service type have the same or similar dates of service, same procedures and/or diagnosis and other similarities.

7. Inappropriate Lump Sum Charge - This code will be used when the claim includes dollar amounts paid for which a unit of service was not specified or for which the dollar amounts cannot be assigned so that the total amount paid can be reviewed. This code will be used for situations described in Subchapter 3612.

The other nature codes are self-explanatory. A code 0|0 preceeds all error codes to indicate on the claims processing worksheet that no errors were found for that element.

3630 REVIEW PROCESS DOCUMENTATION AND PROCEDURES

This section provides procedures for conducting the reviews and the methods used to compute and document claims processing errors.

3631 Claims Processing QC Review Criteria

In the following two columns are the data needs and criteria documents against which the QC reviewer examines each claim.

The criteria documents vary greatly from State to State as reference sources. In no situation is the claims processing reviewer dependent upon access to the beneficiary case record.

Data Needs	Criteria Documents
1. Paid Claims for Services Provided During the Review Month to all Beneficiaries in the Sample.	1. Computer generated paid claim file; microfilm copy of paid claims by beneficiary; copy of provider invoices
2. Provider Invoices for Services Provided During the Review Month, to all Beneficiaries in the Sample	2. Microfilm; microfiche files; copy records.
3. Eligible Providers for the Review Month.	3. Computer generated listing of eligible providers for the review month.
4. Allowable Payments for Services During the Review Month.	4. Specified fee schedules by service area; listing of payment screens or edits used in claims processing; relative value scales (RVSs) for services and conversion factors (RVS multiplied by conversion factor yields fee); listing of "usual and customary" charges by provider group; hospital and nursing home reimbursement guides or manuals.
5. Services Covered by the State Medicaid Program	5. Provider manuals can specify; drugs covered can be listed in a formulary, specifies either all drugs covered or only those drugs included as covered; State plans may specify general areas not covered; fee schedules should specify; hospital reimbursement manuals.

6. Prior Approval Requirements	6. Provider manual can specify; State plans can specify; fee schedules may specify requirement.
7. Service Frequency Limitations.	7. Provider manuals and State plans may specify; fee schedules can specify limits; screens or edits used in claims processing may specify.
8. Physician Certification Policy for Hospital or Long Term Care Service.	8. Claims processing certification files, varies by State.

All criteria documents must be valid or in force for the review month since the review of paid claims is unique to a prescribed interval in time (review month).

3632 Claims Processing Error Worksheet & Summary Sheet

Exhibit 3600-3a is the Claims Processing Summary Sheet which contains case information and information about all paid claims reviewed for all beneficiaries for services received during the review month. Exhibit 3600-3b is the Claims Processing Worksheet which is the form to be used for listing claims, dollar amounts, and the errors associated with each claim reviewed.

The Claims Processing QC Worksheet (Exhibit 3600-b) is to be completed first. Two or more worksheets will be completed when there are more than 10 line items in the paid claims reviewed for services provided to case members during the review month. Subtotals will be entered at the bottom of each worksheet. Once the Claims Processing QC Worksheet(s) has been completed, the Claims Processing QC Summary Sheet will be completed.

3633 Steps For Completing the Claims Processing QC Worksheet

1. Enter the QC Review Number in the upper right of the worksheet and the case name and number at the top.

2. Enter the name(s) of the beneficiary(ies) for whom paid claims were reviewed in column (1). All claims for a beneficiary should be listed, if possible, before claims for another beneficiary in the case. If a beneficiary's surname is different from the case name, the surname should be used. If insufficient spaces are available, use the first and middle initial of the beneficiary along with the surname.

3. For each claim, enter the claim number below the name of the beneficiary and the paid amount of the claim in Column (2),"Dollar Amount of Claim Paid". Specific line items on an invoice should be identified by a suffix to the claim number.

4. For each claim, enter the date of service in column (4).

5. For each claim, enter the type of service in column (5). The service codes are listed in Exhibit 3600-5.

6. Review each claim for each nature code in the applicable element(s). If no error is found, code 00 is entered in the first of the three spaces provided in the element(s). If more than one nature code is in error, enter each error in the spaces provided. A maximum of 3 nature error codes can be entered in each element.

7. Determine the dollar amount in error and enter this dollar amount in column (3),"Dollar Amount of Claim-Error"

8. When both element 710 and any other element contains at least one error, element 710 is to be considered the primary error for assignment of dollar amount paid-error. Likewise, when more than one nature code is entered within an element, the primary nature code is the nature code which represents the greater dollar amount.

9. This process is repeated for all paid claims reviewed for case members.

10. The dollar subtotals are entered in the bottom line of column (2) and (3) on each worksheet.

11. Each worksheet will be numbered in the upper left hand as follows: for cases in which only one worksheet was completed, page 1 of 1; for cases in which two worksheets were completed, page 1 of 2, page 2 of 2; etc.

3634 Steps for Completing the Claims Processing QC Summary Sheet

The Claims Processing QC Summary Sheet is completed using data from the Claims Processing QC Worksheet(s). (See Exhibit 3600-3a). The reviewer will follow the steps listed below in completing the Summary Sheet:

Form HCFA-301 E(ii) (3/78)
Department of Health, Education and Welfare
Health Care Financing Administration

OMB No. 066-R-0107
Expires 3/79

CLAIMS PROCESSING QC SUMMARY SHEET

Review Number

Case Number		Dollar Error, by Beneficiary
Case Name		
Beneficiary Name(s)		
	Total Case	

Total Number of Paid Claims

Total Dollar Amount of Paid Claims $

Total Number of Paid Claims in Error

Dollar Amount of CP Errors $

QC Review No.

Date Review Completed

NATURE CODE ERROR FREQUENCY ANALYSIS

Element Codes	Error Frequency, By Nature Code										Freq., by Element	Dollar Amt. of Error by Element
	01	02	03	04	05	06	07	08	09			

Reviewer Signature _____

Form HCFA-301 E(i) (3/78)
Department of Health, Education and Welfare
Health Care Financing Administration

OMB No. 066-R-0107
Expires 3/79

CLAIMS PROCESSING QC WORKSHEET

Review Number

Case Number

Case Name

(1) Beneficiary Name and Claim Number	Dollar Amount of Claim (2) Paid	Dollar Amount of Claim (3) Error	Date of Service (4)	Type of Service (5)	Completion of Claim (710)	Inpatient Hospital Services (720)	Physicians Services (730)	Long-Term Care (740)	Pharmacy Services (750)	EPSDT Services (760)	Other Services (770)
				-							
				-							
				-							
				-							
				-							
				-							
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				-							
				-							
TOTALS ($)											

1. Enter the case number and the case name where indicated;

2. Enter the name(s) of the beneficiary(ies) in the order used on the Claims Processing Worksheet(s).

3. Enter the claims processing error dollars associated with each beneficiary in the column "Dollar Error By Beneficiary". (i.e., 0|0|0|6|5 or if no error 0|0|0|0|0 .)

4. Enter the total claims processing error dollars in the bottom line of the column adjacent to "Total Case". (i.e., 0|0|0|8|4 .)

5. Enter total number of claims where indicated (i.e., 0|0|1|0)

6. Enter total paid dollars for all claims where indicated. (i.e., 0|0|3|5|9 .)

7. Enter total number of paid claims with dollar amounts in error where indicated. (i.e., 0|0|7 .)

8. Enter total dollar amount paid in error where indicated. (i.e., 0|0|0|8|4 .)

9. Enter QC Review number where indicated

10. Enter the date the Claims Processing Review was completed where indicated. (i.e., 0|4|1|5|7|8 .)

11. Accumulate data from the work sheet to show the frequency of each nature code, other than 00, for each element for all paid claims in the case. This data is entered in "Nature Code Error Frequency Analysis".

12. Enter total of nature code errors for each element in column "Frequency by Element".

13. Show total claims processing error dollars for each element in column "Dollar Amount of Error by Element". There can be two elements in error only when element 710 and another element are in error. In these situations, the dollar amount in error is assigned to element 710.

    The other element in error in this case is recorded in the Error Frequency, by Nature Code for corrective action purposes, but no dollar amount is assigned to the second element in error. (Note- it is important to remember that the "Dollar Amount of CP Errors", the "Total Case" dollars

shown under "Dollar Error by Beneficiary" and the total amount of "Dollar Amount of Error by Element" will always be the same.)

14. The claims processing reviewer's name is to be entered in the space provided.

The information contained on the Claims Processing QC Summary Sheet

3640 COMPLETION OF THE CLAIMS PROCESSING REVIEW SCHEDULE

The claims processing portion of the Review Schedule is filled out once the Claims Processing Worksheet and Summary Sheet have been completed.

The claims processing portion of the Review Schedule is presented in Exhibit 3600-4.

VII. Summary of Claims Processing Errors

I. Identifying Information
These items need to be completed for each case for which paid claims for services received during the review month were reviewed.

II. Case Information

A. Number of Recipients of Medical Services During the Review Month - This item provides for recording the number of beneficiaries in a case who received services during the review month for which paid claims were reviewed by the QC reviewer. The source of this information is the Claims Processing QC Worksheet(s). The number of beneficiaries in a case for whom Medicaid paid claims for review month services should be entered in Item A. Two digits should always be entered, e.g., 0 1 .

B. Number of Paid Claims - Item B records the total number of paid claims for review month services for all members of the sampled case. Paid claims for both eligible and ineligible beneficiaries should be included in the count for Item B, e.g., 0 0 7.

C. Types of Review Month Services - The types of review month services for which Medicaid paid claims are entered in Item C. The QC reviewer will enter the appropriate code, shown in Exhibit 3600-5, for each different type of service for which a claim was paid. If two or more claims are for the same service type, only one entry of that service type code is required. If more types of services are received than there are spaces in Item C, the reviewer will enter in Item C, the services for which the largest dollar amounts were paid.

D. Dollar Amount of Paid Claims - The total dollar amount paid by Medicaid for all review month services for all beneficiaries of the sampled case, should be recorded in Item D. The QC reviewer should sum the dollars and cents of the paid claims

for all case members. Once the dollar amounts have been summed the total should be rounded to the nearest whole dollar. In cases where the cents are 49¢ or less, the dollar amount remains the same. In cases where the cents are 50¢ or more, the dollar amount increases by one. The rounded dollar amount is entered in Item D.

E. Number of Paid Claims with CP Errors - Enter the number of paid claims reviewed in which one or more errors was indicated. This number is the number of times that a dollar amount is recorded in "Dollar Amount of Claim Error".

F. Types of Services with CP Errors - The QC reviewer will enter the appropriate code from those listed in Exhibit 3600-5 for each different type of service for which a claim was paid in error. If two or more claims paid in error are for the same service type, only one entry of that service type code is required. If more types of services were associated with claims paid in error than there are spaces in Item F, the reviewer will enter the services in Item F for which the largest dollar amounts were paid.

G. Dollar Amount of CP Errors - Enter the total amount of all line items in which one or more errors were found. This amount is the total of the dollar amounts which were recorded in "Dollar Amount of Claim-Error".

III. Description of Error

This information is transferred from the Claims Processing QC Summary Sheet, Nature Code Frequency Analysis.

VII. Summary Of Claims Processing Errors

Form HCFA-301 Page 4 of 5 Review No. _____

1. Case Name	2. Address	3. Case ID Number
4. Review Month	5. Date Claims Processing Review Assigned	6. Date Claims Processing Review Completed	7. Reviewer

(Card 7: Duplicate columns 1-15 from card 1)

A. Number of Recipients of Medical Services During the Review Month (16 17)

B. Number of Paid Claims (18 19 20)

C. Types of Review Month Services (21 22) (23 24) (25 26) (27 28) (29 30)

D. Dollar Amount of Paid Claims (31 32 33 34 35)

E. Number of Claims with CP Errors (36 37 38)

F. Types of Services with CP Errors (39 40) (41 42) (43 44) (45 46) (47 48)

G. Dollar Amount of CP Errors (49 50 51 52 53)

If no olaims were determined to be in error (entriss in Items E, F, and G were 00), no further entry is required

H. Description of Claims Processing Errors

Nature Code Error Frequency Analysis

Element Codes	Error Frequency, by Nature Code									Error Frequency	
	01	02	03	04	05	06	07	08	09	Element	Dollar Amount
710	(54 55)	(56 57)	(58 59)	(60 61)	(62 63)	(64 65)	(66 67)	(68 69)	(70 71)	(72 73)	(74 75 76 77 78)

(Card 8: Duplicate columns 1-15 from card 1)

720	(16 17)	(18 19)	(20 21)	(22 23)	(24 25)	(26 27)	(28 29)	(30 31)	(32 33)	(34 35)	(36 37 38 39 40)
730	(41 42)	(43 44)	(45 46)	(47 48)	(49 50)	(51 52)	(53 54)	(55 56)	(57 58)	(59 60)	(61 62 63 64 65)

(Card 9: Duplicate columns 1-15 from card 1)

740	(16 17)	(18 19)	(20 21)	(22 23)	(24 25)	(26 27)	(28 29)	(30 31)	(32 33)	(34 35)	(36 37 38 39 40)
750	(41 42)	(43 44)	(45 46)	(47 48)	(49 50)	(51 52)	(53 54)	(55 56)	(57 58)	(59 60)	(61 62 63 64 65)

(Card 10: Duplicate columns 1-15 from card 1)

760	(16 17)	(18 19)	(20 21)	(22 23)	(24 25)	(26 27)	(28 29)	(30 31)	(32 33)	(34 35)	(36 37 38 39 40)
770	(41 42)	(43 44)	(45 46)	(47 48)	(49 50)	(51 52)	(53 54)	(55 56)	(57 58)	(59 60)	(61 62 63 64 65)

EXHIBIT 3600-5

SERVICE TYPE CODES

	Type of Service	Code
I.	Institutional Services	
	Inpatient hospital:	
	General hospitals	01
	Mental hospitals	02
	Skilled nursing facilities	03
	Intermediate care facilities:	
	Facilities for mentally retarded	04
	ICF services in all other institutions	05
II.	Noninstitutional Services	
	Physicians's services	11
	Dental services	12
	Other practitioners' services	13
	Outpatient hospital services	14
	Clinic services	15
	Laboratory and radiological services	16
	Home health services	17
	Prescribed drugs	18
	Family planning services	19
	Other services	20

3700 MQC COMPUTATION OF MISSPENT DOLLARS

3710 PURPOSE

The purpose of Chapter 3700 is to provide procedures for completing the following steps in the MQC review:

1. Computing the gross dollar amount of eligibility and case liability errors that occurred during the review month as reflected by paid claims for services provided during the review month for

    a) ineligible beneficiaries
    b) cases with understated liability
    c) cases with overstated liability

2. Computing the unduplicated misspent dollars paid on behalf of a) and b) above plus unduplicated dollars misspent for all claims processing and third party liability errors.

There are two assignments of dollar amounts to case eligibility, CP and TPL errors in the MQC process. The initial assignment of dollar amounts is the determination of gross error amounts for corrective action purposes. These amounts are assigned without consideration of any overlapping impact among the separate error findings of the MQC reviews, namely eligibility, CP, and TPL. In order to calculate the unduplicated amount of misspent dollars in a case with multiple error findings e.g., an ineligible case where CP and TPL errors exist, a second assignment of the dollars associated with each finding is made before combining errors in one unduplicated amount. This unduplicated amount will not exceed the amount of claims paid for services provided to the case during the review month.

3720 DETERMINING GROSS DOLLAR AMOUNTS OF ELIGIBILITY AND LIABILITY ERRORS

In order to compute misspent dollars the reviewer must obtain the following for every sampled case:

1. Eligibility findings for all cases and completed worksheets for the ineligible cases.

2. The CP worksheets.

The worksheets prepared during the MQC review process will provide documentation of the eligibility errors that have been found. The paid claims worksheet will allow the reviewer to associate dollar amount with eligibility errors. The dollar amount of eligibility errors will then be used with the gross dollar amount of the TPL and CP errors to compute unduplicated amounts.

Chapter 3400 of this Manual presented the procedures used to determine whether a case or any member(s) of a case are ineligible or has inaccurately computed liability. In this chapter, the procedures for associating misspent dollar values with the eligibility and liability errors are described.

At this stage in the MQC review, the reviewer should be able to determine the following from the eligibility QC worksheets:

1. The eligibility status of each beneficiary in a case; 1/

2. The amount of understated or overstated liability where these findings occur in a case;

3. The element(s) of eligibility that were found to be in error and nature of errors;

The above constitute the first type of information needed for computing and reporting the dollar value of eligibility and liability errors. In addition, the QC reviewer must have available the dollar amount of paid claims for each beneficiary for services received during the review month.

A major purpose of the MQC system is to measure misspent Medicaid funds. Therefore, if a case is found to be ineligible during the review month, but had no paid claims for services received during that month, then no Medicaid funds have been inappropriately expended. The QC reviewer should note that if there are no claims for a case, the value of an eligibility error for purposes of Chapter 3700 will be 0 (zero).

The dollar amount to be computed for eligibility and liability errors are as follows:

1. For each beneficiary in a case that has been found to be ineligible by MQC review or for each case found to have a liability error, the reviewer must determine the primary error leading to the ineligibility or incorrect liability MQC finding. This primary error must be identified by element, nature and type and the appropriate codes entered on the Review Schedule.

1/ MQC reviewers will not need to review these eligibile AFDC cases in which an AFDC-QC review found an overpayment due to the ineligibility of one case member. Such a case is considered eligible for MQC review purposes. It is not considered cost effective to determine the Medicaid dollars misspent in behalf of this small portion of the Medicaid population.

2. For each primary error the dollar value of the error (based on the review month service claims) must be computed and entered on the Review Schedule.

3. The total unduplicated dollar value of all case ineligibility and liability errors must be computed and entered on the Review Schedule.

This information will be recorded in Section VIII items A, B, and C of the Review Schedule. Procedures for the conduct of each of these steps are discussed below.

3721 Definition of Misspent Dollar Amounts For An Eligibility Or Liability Error

The dollar amount of eligibility or liability errors in Medicaid QC is related to the dollar amount of the claims for services provided to ineligible members or to a case with understated liability during the review month. The following instructions should be followed in costing out the dollar amount of each of the types of errors:

Type of Error	Dollar Amount of Error
1. Case/Case member is ineligible during part or all of the review month.	If ineligible for the entire review month, the dollar error is the full amount of the paid claims for review month services. If eligible during part of the review month, the review month claims should be apportioned on the basis of the dates expenses were incurred. The amount of the review month service claims during the portion of the month in which the beneficiary(ies) was ineligible is the error amount. When it is impractical to determine the date expenses were incurred for any portion of the review month claims, pro-rate such portions on the basis of the number of days ineligible to the total number of days in the review month.

2. Case liability understated during the review month. The value of the understated liability up to the total amount of the review month claims is the dollar error amount. If there are no paid claims for the review month, the misspent dollar amount of the understated liability is zero.

3. Case liability overstated. If the case error is a liability overstated error, the amount of overstated liability is the amount of error for corrective action purposes but the misspent dollar amount is zero.

In cases with multiple errors, the overall dollar amount of error is determined as follows:

1. If at least one error is an eligibility error, the overall dollar amount corresponds to the amount of paid claims for the review month for the ineligible beneficiaries, unless the beneficiary ineligibility is for only part of the review month.

2. In those cases where eligibility and liability errors exist, the case must be redefined and re-evaluated. To re-evaluate the case, the MQC reviewer first removes the ineligible case members from the case, then re-evaluates the eligibility and then, if appropriate, recomputes the liability of remaining case members. The amount of misspent dollars will be calculated by combining the amount of claims paid on behalf of ineligible beneficiaries with the amount of dollars determined to have been misspent because of understated liability after the case has been redefined.

The Review Schedule requires that the dollar amount of eligibility and liability errors be recorded by primary type of error. In cases with multiple beneficiaries with mixed eligibility findings, the first dollar error amount to be computed by the reviewer will be the dollar error amount paid in behalf of ineligible beneficiaries.

Each element in error and the combined dollar error amounts for all ineligible beneficiaries having this same primary error will be listed. No beneficiary will be associated with more than one element in error. If all beneficiaries in a case are found to be ineligible due to the same type of error, the overall case dollar eligibility error amount recorded on the Review Schedule will be the same as the dollar error amount recorded with the primary error for the case. The primary liability error and the dollar amount will then be recorded.

From these gross dollar amounts of eligibility and liability errors by primary type of error, the total dollar amount of misspent funds must be computed by combining the claims paid amounts for all ineligible recipients with the dollar amount of any misspent funds paid on behalf of the case members with understated liability.

3722 IDENTIFY THE PRIMARY ERROR ELIGIBILITY AND LIABILITY ERRORS

The eligibility QC review has determined all of the eligibility and liability errors occurring in a sampled case and recorded up to five of these in Section IV of the Review Schedule. For each sampled case found to be ineligible or to have an ineligible member or to have a liability error, the QC reviewer will determine the error that contributes most substantially to the liability error or to the ineligibility. If the QC worksheets indicate that more than one error contributes to the ineligibility or inaccurate computation, then the MQC reviewer will select the primary error, using the following criteria:

1. If all members of a case have both an eligibility and liability error, the eligibility error is overriding, i.e., (1a.) If case liability has been computed incorrectly and each member of the case fails to meet an element of eligibility, the case is ineligible and all claims paid for the case members during the review month were paid in error. The error would be classified as an eligibility error. (1b.) If case liability has been computed incorrectly and any case members are found ineligible, all claims paid for the ineligible case member(s) during the review month were paid in error. For the remaining eligible members all paid claims up to the amount of the dollar liability were paid in error.

2. If an understated or overstated liability case is found to have multiple errors, the liability error listed first in Section IV of the Review Schedule is the primary error. Only one primary error can be associated with a case liability error.

   If beneficiaries in a case are ineligible for different primary errors, record these errors separately in item VIII A of the Review Schedule in descending order with the greatest error dollar amount first. If the number of beneficiaries exceeds five and the number of primary errors exceeds five, then combine the error dollar amounts for the 5th and any additional beneficiaries into a single error dollar amount. This amount is assigned to the primary for the 5th beneficiary. Identify such a combination by putting 9's in the element, nature and type Boxes for the

5th primary error code row in item A. If the case is a liability case with ineligible members, record the primary liability error on the 5th error code row in item A. Record all other primary eligibility errors as before on the remaining 1 - 4 error code rows in item A. Use code [1] to identify ineligible cases, and code [2] for understated liability cases.

3730 COMPUTING UNDUPLICATED TOTALS OF MEDICAID DOLLARS PAID IN ERROR

The conduct of the MQC review described in the preceding sections of this Manual results potentially in four dollar error amounts. These are as follows:

1. Eligibility dollar error amounts as described in Subchapter 3722;

2. Liability dollar error amounts as described in Subchapter 3722;

3. Third party liability dollar error amounts as described in Subchapter 3570;

4. Claims processing dollar error amounts as described in Subchapter 3630.

Each of these dollar error amounts has been computed using the total amount of paid claims for review month services as the basis for computation. Therefore, if eligibility, TPL and CP errors are identified in a case during the MQC review, the error totals developed thus far in the review may double- or triple-count Medicaid dollars paid for review month services. For example, Medicaid may have paid a $100 claim for a non-covered service for a beneficiary who was found to be ineligible. This $100 error should have been identified and recorded both in the MQC claims processing review and in associating dollar values with eligibility errors. Thus, the $100 has been counted in error twice during previous stages of the review. The purpose of Subchapter 3730 is to provide the MQC reviewer with procedures for computing unduplicated dollar error amounts for eligibility, third party liability and claims processing errors.

While the dollar error totals previously developed during the MQC review may represent duplicated counts of error amounts, they serve as a guide to the magnitude of a Medicaid program's operational problems in the eligibility, TPL and CP areas and, therefore, serve to guide corrective action planning. The Review Schedule provides for recording of both duplicated and unduplicated dollar error amounts. The reviewer should record unduplicated dollar error amounts only in Section VIII of the Review Schedule; no adjustment should be made to the results of the TPL and CP review that are recorded in Sections VI and VII of the Review Schedule.

3731 Hierarchy for Computing Unduplicated Misspent Dollars

In order to compute unduplicated dollar error amounts for the MQC review, an error hierarchy, shown in Exhibit 3700-1, is used. This hierarchy is structured into three levels:

1. The first area of consideration is the eligibility and liability status of the case.

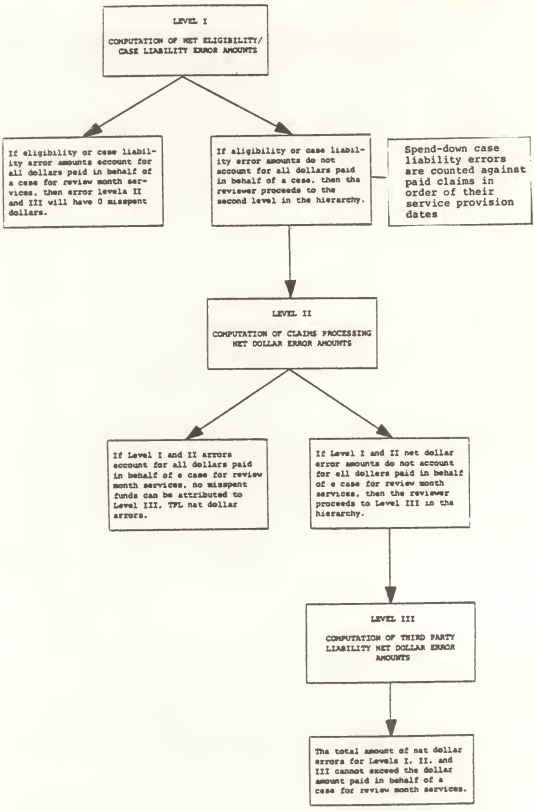
   1a. If eligibility and case liability errors are found during the MQC review, the first attribution of misspent dollars will be to these errors. For example, if all beneficiaries in a case are ineligible for all of the review month, the total dollars paid for review month services will be assigned to the eligibility error category regardless of whether TPL and CP errors were found during the QC review. If there are no eligibility or case liability errors or if errors of these types account for only a portion of the review month paid claims, then the QC reviewer proceeds to the second level in the hierarchy.

   1b. Case liability understatement errors are always attributed to paid claims in order of date of service; i.e., liability errors are always valued using paid claim amounts having the earliest dates of service in the review month. The rationale for this is that beneficiary liability should be met before Medicaid accepts liability for any other claims or otherwise certifies eligibility

2. The second area of consideration in the dollar error hierarchy is whether Medicaid paid provider claims that were not valid under the services coverage and payment policies of the program. These errors are identified during the claims processing QC review.

EXHIBIT 3700-1

THREE LEVEL ERROR HIERARCHY


LEVEL I
COMPUTATION OF NET ELIGIBILITY/ CASE LIABILITY ERROR AMOUNTS
If eligibility or case liability error amounts account for all dollars paid in behalf of a case for review month services, then error levels II and III will have 0 misspent dollars.
If eligibility or case liability error amounts do not account for all dollars paid in behalf of a case, then the reviewer proceeds to the second level in the hierarchy.
Spend-down case liability errors are counted against paid claims in order of their service provision dates
LEVEL II
COMPUTATION OF CLAIMS PROCESSING NET DOLLAR ERROR AMOUNTS
If Level I and II errors account for all dollars paid in behalf of a case for review month services, no misspent funds can be attributed to Level III. TPL nat dollar errors.
If Level I and II net dollar error amounts do not account for all dollars paid in behalf of a case for review month services, then the reviewer proceeds to Level III in the hierarchy.
LEVEL III
COMPUTATION OF THIRD PARTY LIABILITY NET DOLLAR ERROR AMOUNTS
The total amount of nat dollar errors for Levels I, II, and III cannot exceed the dollar amount paid in behalf of a case for review month services.

Claims processing errors are considered before third party liability errors based on the tenet that Medicaid should collect third party funds only for valid claims against the program, and, that payment for claims or portions of claims representing non-compliance with program policies should be adjusted with the source of the error, i.e., usually the provider.

3. The assignment of dollars to third party liability errors is considered last in the dollar error hierarchy. Therefore, only when eligibility, case liability and claims processing errors have not been assigned the total dollar amount of claims paid for services on behalf of a case for a review month, will TPL errors be assigned dollar amount.

3732 Completing the Unduplicated Dollar Error Amount Worksheet

Computations of unduplicated dollar errors by type of error category must proceed on a claim by claim basis for each case. A sample worksheet shown in Exhibit 3700-2 allows the reviewer to record, by beneficiary and claim, the following information:

1. Case and beneficiary name(s);

2. Claim number and date of service provision (for beneficiary liability errors, arrange claims in order of dates of service);

3. Amount paid;

4. Unduplicated eligibility/liability error amounts;

5. Gross or unadjusted CP error amounts taken from Review Schedule and the unduplicated CP error amount, where applicable;

6. Gross or unadjusted TPL error amounts taken from Review Schedule and the unduplicated TPL error amount, where applicable;

7. Unduplicated error totals for each claim.

Vertical totals are provided on the worksheet for summing unduplicated error amounts across all claims and beneficiaries to compute case unduplicated error totals.

The use of the worksheet and the computation of unduplicated (i.e., net) dollar errors is illustrated using the following hypothetical case examples.

UNDUPLICATED DOLLAR ERROR AMOUNT WORKSHEET

Review No._____

1. Case Name	2. Case ID Number	3. Review Month	4. Reviewer

A. CASE and BENEFICIARY NAME	B. CLAIM NUMBER and DATE OF SERVICE	C. AMOUNT PAID	D. ELIGIBILITY/LIABILITY DOLLAR ERRORS (unduplicated)		E. CLAIMS PROCESSING DOLLAR ERRORS		F. THIRD PARTY LIABILITY DOLLAR ERRORS		G. UNDUPLICATED DOLLAR ERROR
		MEDICAID $	Eligibility $	Liability $	Gross $	Unduplicated $	Gross $	Unduplicatsd $	TOTALS $
Subtotals for Page 1									
Subtotals for Page 2									
TOTALS									

3733 Examples of Unduplicated Error Computation

3733.1 Single Error Case

Exhibit 3700-3 depicts three single error sample cases on a single worksheet. Sample Case 1 reflects the identification of total review month ineligibility for all members in the case. Sample Case 2, which is comprised of one beneficiary, reflects the occurrence of a single CP error. In Case 3, the MQC review identified only a TPL error. In each of the three sample cases shown in Exhibit 3700-3, only one of the three possible types of errors has occurred (i.e., eligibility/liability or TPL or CP). Therefore, the full dollar amount of misspent funds is assigned to the one appropriate error category.

3733.2 Multiple Error Cases: Eligibility/Liability, CP, and TPL

Exhibit 3700-4 depicts a sample case (Sample Case 4) in which liability understated, CP and TPL errors were identified during the MQC review. The reviewer would therefore need to assign dollar error values according to the use of the hierarchy discussed previously in this Chapter.

Sample Case 4 in Exhibit 3700-4 can be described as follows: During the review month, the beneficiary in a one person case had a one day stay in a hospital for a tonsillectomy. The Medicaid fee schedule in this example State has a policy that $185 is the all-inclusive fee for this procedure, but a $200 claim was submitted by the provider and was paid by Medicaid. During the MQC review, the case was found to have a $100 understated liability error. The claims processing QC review identified the $15 overpayment and the TPL review verified that the beneficiary was covered by Blue Cross/Blue Shield and her policy would have covered the entire amount of the claim. Computations of the unduplicated dollar error amounts would proceed as follows:

1. $100 of the $200 paid claim is the understated liability error amount.

2. The portion of the claim dollars that can be attributed to either CP or TPL errors is determined by subtracting the liability error amount ($100) from the total paid claim amount. ($200). Therefore, in this example, the sum of unduplicated CP and TPL dollar errors cannot exceed $100.

UNDUPLICATED DOLLAR ERROR AMOUNT WORKSHEET

Review No.

1. Case Name	2. Case ID Number	3. Review Month	4. Reviewer

A. CASE and BENEFICIARY NAME	B. CLAIM NUMBER and DATE OF SERVICE	C. AMOUNT PAID MEDICAID $	D. ELIGIBILITY/LIABILITY DOLLAR ERRORS (unduplicated) Eligibility $	D. Liability $	E. CLAIMS PROCESSING DOLLAR ERRORS Gross $	E. Unduplicated $	F. THIRD PARTY LIABILITY DOLLAR ERRORS Gross $	F. Unduplicated $	G. UNDUPLICATED DOLLAR ERROR TOTALS $
Case 1									
Doe, John	02137 (3-15)	100	100	—	0	0	0	0	100
Mary	02842 (3-18)	50	50	-	0	0	0	0	50
Case 1 & Error Totals			150						150
Case 2									
Brown, Al	03176 (4-1)	50	0	0	25	25	0	0	25
Case 2 & Error Totals						25			25
Case 3									
Jones, Don	01763 (4-2)	80	0	0	0	0	10	10	10
Case 3 & Error Totals								10	10
Subtotals for Page 1									
Subtotals for Page 2									
TOTALS									

Form HCFA-301 F (3/78)
Department of Health, Education and Welfare
Health Care Financing Administration

OMB No. 066-R-0107
Expires 3/79

EXHIBIT 3700-4

UNDUPLICATED DOLLAR ERROR AMOUNT WORKSHEET

Review No. 4392

1. Case Name	2. Case ID Number	3. Review Month	4. Reviewer
Mary Doe	624-89-1273	6/77	Harris

A. CASE and BENEFICIARY NAME	B. CLAIM NUMBER and DATE OF SERVICE	C. AMOUNT PAID MEDICAID $	D. ELIGIBILITY/LIABILITY DOLLAR ERRORS (unduplicated)		E. CLAIMS PROCESSING DOLLAR ERRORS		F. THIRD PARTY LIABILITY DOLLAR ERRORS		G. UNDUPLICATED DOLLAR ERROR
			Eligibility $	Liability $	Gross $	Unduplicated $	Gross $	Unduplicated $	TOTALS $
Case 4 Doe, Mary	17886 (6-1)	200	-	100(4)	15	15	200	85	200
Subtotals for Page 1				100		15		85	200
Subtotals for Page 2									
TOTALS				100		15		85	200

3. A "gross" claims processing error of $15 overpayment has been identified during the MQC review; the entire $15 can be counted in the unduplicated CP dollar error amount because only $100 of the $200 claim has been attributed to the liability error.

4. The portion of the claim dollars which can be assigned to TPL error is determined by subtracting the liability error amount plus the CP error amount from the total paid claim amount, Therefore, in this example, the unduplicated TPL dollar error amount is $85. ($200 - $100 for liability - $15 for CP error).

Although the MQC review determined that the entire amount of the paid claim ($200) was covered by a third party, the unduplicated dollar error amount for TPL cannot exceed $85 because of the liability and CP dollar error amounts already computed. Any TPL error figure in excess of $85 would result in a larger error amount than the amount of the claim when added to the CP and liability dollar error amounts. This situation is never allowable in the computation of unduplicated dollar errors.

In the example listed above, the total amount of the claim was found by QC review to be paid in error. Given the various possible outcomes of each phase of MQC review, total unduplicated dollars paid in error may range from 0 to the total amount of the claim. The standard computation method which has been illustrated in the example given above requires that the reviewer subtract the computed dollar error value for eligibility from the total paid claim in order to determine how many dollars may be attributed to the CP and TPL error categories. That is, eligibility and liability understated error dollars are subtracted from the total paid claim amount to determine the dollars that can be associated with CP errors, where these are present. Only after adjusting the remaining total for CP errors can the unduplicated dollar value of TPL errors be determined.

3733.3 Multiple Error Case: Eligibility CP and TPL

Sample Case 5, shown in Exhibit 3700-5 depicts a 2 member case for which MQC review had identified eligibility, CP, and TPL errors. Because both case members were found by MQC review to be ineligible during the entire review month the total value of the paid claims for the review month is attributed to the eligibility dollar error amount. Therefore, the "unduplicated" values of any CP and TPL errors identified must be 0, because the "unduplicated" or "misspent" dollar amount for all three categories cannot exceed the total amount paid for services received during the review month.

Form HCFA-301 F (3/78)
Department of Health, Education and Welfare
Health Care Financing Administration

EXHIBIT 3700-5

OMB No. 066-R-0107
Expires 3/79
Chapter 3700 page 14

UNDUPLICATED DOLLAR ERROR AMOUNT WORKSHEET

Page 1 of 2

Review No. 92683

1. Case Name	2. Case ID Number	3. Review Month	4. Reviewer
Sam Davis	421-83-6294	3/78	Coleman

A. CASE and BENEFICIARY NAME	B. CLAIM NUMBER and DATE OF SERVICE	C. AMOUNT PAID MEDICAID $	D. ELIGIBILITY/LIABILITY DOLLAR ERRORS (unduplicated) Eligibility $	Liability $	E. CLAIMS PROCESSING DOLLAR ERRORS Gross $	Unduplicated $	F. THIRD PARTY LIABILITY DOLLAR ERRORS Gross $	Unduplicated $	G. UNDUPLICATED DOLLAR ERROR TOTALS $
Case 5									
Davis, Sam	01760 (3-2-78)	100	100	-	50	0	35	0	100
Mary	03721 (3-9-78)	100	100	-	10	0	20	0	100
Subtotals for Page 1			200			0		0	200
Subtotals for Page 2			-			-		-	-
TOTALS			200			0		0	200

3733.4 Multiple Error Case; Multiple Errors for Each Member

The examples of multiple errors given thus far have focused on relatively small cases with only a few claims. Occasionally, more complex situations will arise. Sample Case 6, shown in Exhibit 3700-6, illustrates a case with liability understated by $200, gross CP errors of $70, gross TPL errors of $260. These errors are spread among seven claims and two beneficiaries both of whom are eligible. The claims are arranged in chronologic order to facilitate the application of the spend-down liability error of $200.

According to the hierarchy for computing unduplicated misspent funds,case liability error is applied against paid claims in order of their service provision dates. Therefore, unduplicated liability error of $200 is applied against claim 1337, 1246, and $15 of claim 1270. There can be no additional unduplicated error amounts for CP and TPL since the total amount of the paid claim has already been applied to the case liability error.

For claim 1270, the CP error of $20 was due and payment for an uncovered service. Since $15 of this error was already attributed to the case liability error, only $5 remains to be attributed to the CP unduplicated amount. Claim 1370 showed $20 in gross TPL error, and the full $20 is written off to unduplicated TPL dollar error. Claim 1820 has no errors. Claim 3740 shows $15 for gross CP error and $50 for gross TPL. Each of these amounts are attributed to CP and TPL unduplicated error. Claim 4330 shows only a $30 gross TPL error and the $30 is properly attributed to unduplicated TPL dollar error.

The unduplicated error total for each claim appears in the last vertical column and the case summary unduplicated error total appears on the bottom row. The total of $320 in unduplicated error is the correct sum both vertically and horizontally. This summing procedure helps to insure against computational errors. The major point to be made about Sample Case 6 is the manner in which the spend-down case liability error is computed.

Sample Case 7, shown in Exhibit 3700-7 illustrates the computation of unduplicated dollar error where there is some overlap of gross error against the same medical service. That is, gross error rates may double or triple-count a paid claim for a particular service. In doing the unduplicated count, misspent funds can only be attributed to a portion or all of the same claim, one time.

Form HCFA-301 P (3/78)
Department of Health, Education and Welfare
Health Care Financing Administration

EXHIBIT 3700-6

OMB No. 066-R-0107
Expires 3/79
Chapter 3700 page 16

UNDUPLICATED DOLLAR ERROR AMOUNT WORKSHEET

Review No. 216801

1. Case Name	2. Case ID Number	3. Review Month	4. Reviewer
Tim Brown	426-00-8217	4/78	Johnson

A. CASE and BENEFICIARY NAME	B. CLAIM NUMBER and DATE OF SERVICE	C. AMOUNT PAID MEDICAID $	D. ELIGIBILITY/LIABILITY DOLLAR ERRORS (unduplicated)		E. CLAIMS PROCESSING DOLLAR ERRORS		F. THIRD PARTY LIABILITY DOLLAR ERRORS		G. UNDUPLICATED DOLLAR ERROR
			Eligibility $	Liability $	Gross $	Unduplicated $	Gross $	Unduplicated $	TOTALS $
Brown, Tim	1337 (4-1)	10	-	10	10	0	10	0	10
,Tim	1246 (4-2)	175	-	175	25	0	150	0	175
,Tim	1270 (4-3)	20	-	15	20	5	0	0	20
,Linda	1370 (4-4)	47	-	-	0	0	20	20	20
,Linda	1820 (4-7)	10	-	-	0	0	0	0	0
,Linda	3740 (4-9)	65	-	-	15	15	50	50	65
,Linda	4330 (4-10)	75	-	-	0	0	30	30	30
Subtotals for Page 1				200		20		100	320
Subtotals for Page 2				-		-		-	-
TOTALS				200		20		100	320

UNDUPLICATED DOLLAR ERROR AMOUNT WORKSHEET
(continued)

A. CASE and BENEFICIARY NAME	B. CLAIM NUMBER and DATE OF SERVICE	C. AMOUNT PAID	D. ELIGIBILITY/LIABILITY DOLLAR ERRORS (unduplicated)		E. CLAIMS PROCESSING DOLLAR ERRORS		F. THIRD PARTY LIABILITY DOLLAR ERRORS		G. UNDUPLICATED DOLLAR ERROR
		MEDICAID $	Eligibility $	Liability $	Gross $	Unduplicated $	Gross $	Unduplicated $	TOTALS $

In Sample Case 7, Sam Jones experienced a three-day inpatient hospital stay. The invoice stated that he was admitted on 4-1-78 and discharged on 4-3-78. The hospital negotiated an all-inclusive based accommodation rate of $150 per day to include room and nursing service, limited radiology and laboratory. Ancillary services (inhalation therapy) were not included in the all-inclusive basic accommodation rate and were billed separately. At the end of Mr. Jones' hospital stay the provider billed the Medicaid agency for 3 days of stay ($450) and for the delivery of inhalation therapy service on the first day of stay (4-1-78) for $50. The Medicaid agency paid the claim.

Upon MQC review it was discovered that Mr. Jones had an error of $200 of understated spend-down liability. Furthermore, the inhalation therapy service paid on the first day of stay was a non-covered service according to State Medicaid coverage policy. Finally, Mr. Jones was found to have TPL coverage through an old insurance policy that would have paid $50 for each day of stay applied to accommodation charges and $40 toward the inhalation therapy. None of this TPL coverage was known to or pursued by the Medicaid agency.

Exhibit 3700-7 illustrates how the MQC reviewer would compute misspent funds for the case. The hospital claim contained only two line items, accommodation charges and the inhalation therapy charge. For purposes of computing unduplicated misspent funds the reviewer has broken down the lump sum charge of $450 for accommodation into $150 per day for each of the three days. The inhalation therapy charge of $50 is recorded in its proper chonological order.

Misspent funds of $200 are attributable to the case liability error according to the hierarchy and applied to the first two charges; i.e., the first day's accommodation rate of $150 and to the claims processing error of $50. Because these erroneous payments are already assigned to the case liability error, no misspent funds can be assigned to the CP error; i.e., misspent funds can be assigned only once to the same service although gross error rates may overlap that service.

In the example, the TPL gross error of $50 per day for daily accommodation charge represents an unduplicated $50 per day misspent funds for the service dates of 4-2 and 4-3.

Error Category	Gross Error	Unduplicated Misspent Funds
1. Case liability understated	$200	$200
2. CP Errors	$ 50	0
3. TPL Errors	$190	$100
Totals	$440	$300

There are several important points pertinent to this case. First, some claims particularly in-patient, may present line item charges in lump sums. Where feasible, the MQC reviewer must breakdown these sums into daily charges by date of service. Second, when the case involves a case liability error, it is useful to array the claims data on the worksheet in chronological order so that the liability error can be assigned to services as they were provided in chronological order. Payments for all services received are erroneous payments due to the case liability error until spend-down liability has been met! Thereafter, computation of unduplicated error proceeds according to the hierarchy; first CP errors, then TPL.

This will complete the computation of unduplicated misspent funds for each type of error.

3740 COMPLETION OF THE REVIEW SCHEDULE

One final section of the Review Schedule must be completed before closing an MQC case review. Section VIII of the Review Schedule includes documentation of dollar amounts of eligibility errors and unduplicated dollar amounts of TPL and CP errors. The remainder of Chapter 3740 provides instructions for completing the section of the Review Schedule, which is shown as Exhibit 3700-8.

3741 Instructions for Completing Section VIII Of The Review Schedule

Section VIII of the Review Schedule provides for recording the dollar amounts of Medicaid funds paid in error for review month services. Items A-C relate to dollar error and other findings of the eligibility QC review. The Item D entry reflects unduplicated dollar amounts associated with claims processing errors and Item E is the MQC record of unduplicated dollar errors associated with third party liability errors. Items A through F are completed as follows:

Form HCFA-301 F (3/78)
Department of Health, Education and Welfare
Health Care Financing Administration

OMB No. 066-R-0107
Expiree 3/79

EXHIBIT 3700-7

Chapter 3700 page 20

UNDUPLICATED DOLLAR ERROR AMOUNT WORKSHEET

Review No. 8354

1. Case Name	2. Case ID Number	3. Review Month	4. Reviewer
Sam Jones	616-01-5105	4/78	Howard

A. CASE and BENEFICIARY NAME	B. CLAIM NUMBER and DATE OF SERVICE	C. AMOUNT PAID MEDICAID $	D. ELIGIBILITY/LIABILITY DOLLAR ERRORS (unduplicated) Eligibility $	D. Liability $	E. CLAIMS PROCESSING DOLLAR ERRORS Gross $	E. Unduplicated $	F. THIRD PARTY LIABILITY DOLLAR ERRORS Gross $	F. Unduplicated $	G. UNDUPLICATED DOLLAR ERROR TOTALS $
Jones, Sam	01273 (4-1)	150	-	150	0	0	50	0	150
	(4-1)	50	-	50	50	0	40	0	50
	(4-2)	150	-	0	0	0	50	50	50
	(4-3)	150	-	0	0	0	50	50	50
Subtotals for Page 1				200		0		100	300
Subtotals for Page 2				-		-		-	-
TOTALS				200		0		100	300

A. Dollar Value of Primary Elgibility/Liability Error - Item A provides for recording the dollar values of eligibility and liability errors in conjunction with the primary source (i.e., element, nature and type) of error. The procedures for determining the primary error and associated dollar values of these errors are described in Subchapter 3720. In order to complete Item A on the Review Schedule, the QC reviewer must have identified each different primary error in the case and computed the associated dollar error amount. According to the procedures in Subshapter 3720, there can never be more than one primary error per beneficiary in a case. If each beneficiary's primary error is the same for a multi-member case, only one type of primary error will be identified in Item A.

Primary errors will be identified using the same error coding scheme as is presented in Subchapter 3493 as explained under Item T, Section IV of the Review Schedule. For each primary error, the appropriate element, nature and type code must be entered under Item A. As well, the number of beneficiaries in the case represented by the primary error codes must be entered. The final entry in Item A is the dollar value of the primary liability or eligibility error. The procedures for computing this dollar value are given in Subchapter 3720.

All dollar amounts entered in Item A should be rounded to the nearest dollar as per instructions in earlier chapters of this Manual. Five digits should be entered, e.g.,

0	0	0	5	3

for $53 in error.

Enter zeros in Item A for primary errors with a zero (0) dollar consequence.

B. Total Dollar Amount of Unduplicated Case Eligibility Errors - Item B is to be completed by the reviewer for each case reviewed. The total dollar amount of case eligibility errors is to be recorded. If the case has no eligibility dollar errors, zeros should be entered for Item B. The method of computing this total is presented in Subchapter 3722. After determining the dollar error amount for each ineligible beneficiary in the case (whether for the total review month or part of the month), the QC reviewer sums the dollar errors for each beneficiary to get the case total which is entered in Item B. Five digits must be entered in Item B. Note this dollar amount is not necessarily the sum of the entries in Item A.

C. Total Dollar Amount of Unduplicated Understated Liability Errors - Item C is to be completed for each case reviewed. If the case has no liability dollar errors, or an overstated liability error, zeros should be entered for Item C. Only dollar errors associated with inaccurate understated liability computations are to be recorded in Item C. Computation of the dollar value of these errors is described in Subchapter 3722. For each case, the net effect of liability errors for all beneficiaries in the case is to be recorded in Item C. Five digits are to be recorded. Note this dollar amount is not necessarily the sum of the entries in Item A.

D. Unduplicated Dollar Amount of Claims Processing Errors - Item D is to be completed for each case reviewed. If there is no unduplicated claims processing error amount, zeros are to be entered in Item D. After computing the unduplicated CP error amount by one of the computation methods given in Subchapter 3730, the reviewer will enter the case total in Item D. Five digits are to be entered.

E. Unduplicated Dollar Amount of Third Party Liability Errors -

Item E is to be completed for every case reviewed. If there is no unduplicated TPL error amount zeros are to be entered in Item E. Instructions for computing the unduplicated third party liability error amount, using one of the appropriate computation methods, are given in Subchapter 3730. The entry in Item E reflects the TPL error amount after adjustment for dollar amounts of eligibility errors and unduplicated CP error amounts. Five digits are to be entered in Item E.

F. Enter total dollar amount of unduplicated misspent funds. (The total of B, C, D, E). If there are no misspent funds enter zeros in Item F.

VIII. Summary of Payment Errors

Review No. _____

Form HCFA-301 Page 5 of 5

1. Case Name	2. Address	3. Case ID Number
4. Review Month	5. Date Payment Review Assigned	6. Date Payment Review Completed	7. Reviewer

(Card 11: Duplicate columns 1-15 from card 1)

A. Dollar Value of Primary Eligibility/Liability Error(s)

Error	Error Finding	Element	Nature	Type	# of Members with Error	Dollar Amount
1.	16	17 18 19	20 21	22 23	24 25	26 27 28 29 30
2.	31	32 33 34	35 36	37 38	39 40	41 42 43 44 45
3.	46	47 48 49	50 51	52 53	54 55	56 57 58 59 60
4.	61	62 63 64	65 66	67 68	69 70	71 72 73 74 75

(Card 12: Duplicate columns 1-15 from card 1)

5.	16	17 18 19	20 21	22 23	24 25	26 27 28 29 30

B. Total Unduplicated Dollar Amount of Case Eligibility Errors — 31 32 33 34 35

C. Total Unduplicated Dollar Amount of Case Liability Errors — 36 37 38 39 40

D. Total Unduplicated Dollar Amount of Case Claims Processing Errors — 41 42 43 44 45

E. Total Unduplicated Dollar Amount of Third Party Liability Errors — 46 47 48 49 50

F. Total Unduplicated Dollar Amount of Medicaid Mis-spent Funds for the Case — 51 52 53 54 55

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